Removing communication barriers for people who are
Deaf • Hard of Hearing • Late-Deafened • Deaf-Blind • Speech Disabled

National Deaf-Blind Equipment Distribution Program Application

The National Deaf Blind Equipment Distribution Program (NDBEDP) is a national program required by the Twenty-First Century Communications and Video Accessibility Act (CVAA) that provides $10 million annually for the distribution of communications equipment to low-income individuals who are deaf-blind. The Office of the Deaf and Hard of Hearing (ODHH) has been selected by the Federal Communication Commission (FCC) to administer the NDBEDP. Washington State will receive approximately $197,000 for the first year of the two-year NDBEDP pilot project.

Applicant must meet the following criteria to be eligible to participate in the NDBEDP:

- **Verification of Disability:** Applicants must meet the Helen Keller National Center (HKNC) definition of Deaf-Blind which states an individual is Deaf-Blind when they:
  1. Have a central visual acuity of 20/200 or less in the better eye with corrective lenses, or a field defect such that the peripheral diameter of visual field subtends an angular distance no greater than 20 degrees, or a progressive visual loss having a prognosis leading to one or both these conditions;
  2. Have a chronic hearing impairment so severe that most speech cannot be understood with optimum amplification, or a progressive hearing loss having a prognosis leading to this condition; and
  3. Have the combination of impairments described in 1 and 2 above cause extreme difficulty in attaining independence in daily life activities, achieving psychosocial adjustment, or obtaining a vocation.

- **Income Eligibility:** Applicant must meet income eligibility requirements that do not exceed 400 percent of the Federal Poverty Guidelines (FPG). NDBEDP applicants are required to provide proof of income.

### 2012 Federal Poverty Guidelines for Washington

<table>
<thead>
<tr>
<th>Number of persons in family / household</th>
<th>400%</th>
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<tr>
<td>1</td>
<td>$44,680</td>
</tr>
<tr>
<td>2</td>
<td>60,520</td>
</tr>
<tr>
<td>3</td>
<td>76,360</td>
</tr>
<tr>
<td>4</td>
<td>92,200</td>
</tr>
<tr>
<td>5</td>
<td>108,040</td>
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<tr>
<td>6</td>
<td>123,880</td>
</tr>
<tr>
<td>7</td>
<td>139,720</td>
</tr>
<tr>
<td>8</td>
<td>155,560</td>
</tr>
<tr>
<td>For each additional person, add</td>
<td>$15,840</td>
</tr>
</tbody>
</table>

Source: Adapted from U.S. Department of Health and Human Services (aspe.hhs.gov/poverty/12poverty.shtml)
Filling out the application

- Please read the instructions and review the application.
- Complete the application and send it to ODHH, ATTN: NDBEDP at the Olympia WA address below.

This section gives step-by-step instructions for filling out the NDBEDP Application (pages 5 - 7). Instructions below are written so that “You” means the person who is applying for telecommunication equipment.

Do you need help filling out the application?

If you are unable to fill out the application yourself, you may ask another person to fill it out for you. Some people to ask for help might be (but is not limited to): a family member, friend, caregiver, guardian, case manager, doctor, audiologist, or another professional. The person who is filling out the application must enter the information of the person who is applying for the equipment.

Regional Service Centers (RSC) for the Deaf and Hard of Hearing

The Office of the Deaf and Hard of Hearing (ODHH) supports eight (8) Regional Service Centers (RSC) in the State of Washington. RSC Advocates work with people who are Deaf, Hard of Hearing, Late-Deafened, and Deaf-Blind. You may contact your local RSC for help filling out the application. Advocates may also sign the professional certification on page 7, section 6 of the application.

Contact ODHH to find the RSC in your area:

<table>
<thead>
<tr>
<th>ODHH</th>
<th>(800) 422-7930 V/TTY</th>
<th>VP: 360-339-7382</th>
</tr>
</thead>
<tbody>
<tr>
<td>PO Box 45301</td>
<td>(360) 902-8000 V/TTY</td>
<td>E-mail: <a href="mailto:ndbedp@dshs.wa.gov">ndbedp@dshs.wa.gov</a></td>
</tr>
<tr>
<td>Olympia, WA 98504-5301</td>
<td>(360) 902-0855 FAX</td>
<td>Web: <a href="http://odhh.dshs.wa.gov">http://odhh.dshs.wa.gov</a></td>
</tr>
</tbody>
</table>

Instructions for completing the Application for Telecommunication Equipment

Section 1. Information

1. Name. Enter your last name, first name, and middle initial.
2. Gender. Select your gender. Check: male or female.
3. Address. Enter your home address: Street, City, State, and Zip Code. You must enter a 5-digit zip code. You may enter a 9-digit zip code, if known.
4. Mailing address. Enter your mailing address (same format as #3), if different than your home address. Mailing address may be a Post Office box, Rural Route, or other location where you receive mail.
5. Community/facility name. Enter the name of the facility you live in. A “facility” may be an apartment complex, adult family home (AFH), or nursing home.
6. County. Enter the county you live in.
7. Home telephone number. Enter your home telephone number, in the following format: (area code) phone number. Check the type of phone number it is: Voice, TTY, Fax, or Video Phone (VP).
8. Message telephone number. Enter a message telephone number where ODHH may call to leave messages for you.
9. E-mail address. Enter your e-mail address, if you have one. ODHH may contact you by e-mail, if necessary.
10. **Best times to contact.** Enter best times to contact you. ODHH will contact you during that time, if possible.

11. **Social Security Number (optional).** Enter your Social Security Number (SSN). This is optional.

12. **Date of Birth.** Enter your Date of Birth in the following format: MM/DD/YYYY (example: 12/06/1981).

13. **Race/Ethnicity (optional).** Check the box that best describes your race or ethnicity. This is optional.

14. **Financial information.** Enter your family size (number of people living with you), and all sources of income: monthly and estimated annual (one year) income. You must complete this section. You must provide proof of income in the form of pay stubs, most recent tax return, SSI, SSDI, or other benefits documentation. You can contact ODHH if you have questions about other documents you may be able to use to prove income.

**Section 2. Profile**

1. **Hearing Loss.** Check the box that best describes your level of hearing

2. **Vision.** Check the box that best describes your vision.

3. **Hand Coordination.** Check whether or not you have difficulty using your hands for keyboarding, dialing the phone, or holding small objects.

4. **Communication Preference.** Check all boxes that identify the Client’s communication preferences. See below for definitions of the different types of communication preferences.

   - **American Sign Language (ASL):** Visual and gestural language with linguistic rules that are different from English and any other language. ASL is used by Deaf people in the United States and some parts of Canada.

   - **Pidgin Sign Language (PSE):** A form of sign language that arises from contact between ASL and spoken English.

   - **Sign Exact English (SEE):** Visual and manual communication that represents the English language, verbatim.

   - **High Visual Communication Skills (HVCS/MLS):** Use of gestures, visual concepts, or home signs. Generally, people with HVCS do not know ASL and/or spoken/written English. Formerly known as Minimal Language Skills.

   - **Tactile Sign Language:** A Deaf-Blind person places their hand over another person’s hand who is signing. This allows a Deaf-Blind person to receive signed visual and expressive communication from a person.

   - **Close-Vision Sign Language:** A Deaf-Blind person with usable, limited field of vision who can see a person signing within a limited distance. Depending on visual needs, a person may sign using a limited or larger signing space.

   - **Spoken Language:** Communicate by speech, sometimes the oral approach. The person may use auditory aids, such as digital hearing aids, cochlear implants, and lip-reading to communicate. If the client speaks a foreign language, identify the foreign language.

   - **International Sign Language:** A sign language used by a person from another country, who does not communicate in ASL or English.

   - **Other:** Other form of communication not listed.

5. **Reading.** Check the boxes that indicate what formats you currently read.
Section 3. Communication Methods
1. Communication activities. Check all current activities you perform.
2. Communication equipment. Check all equipment you currently use.

Section 4. Program Goals
Please describe what type of communication access you hope to achieve by participation in the NDBEDP.

Section 5. Client Signature
1. Signature and date. You must sign and date the application. If you are unable to sign and date the application, the person who is filling out the application for you may sign on your behalf.
2. Person completing the application. If you are not filling out the application for yourself, the person who is filling out the application must enter: their name, relationship to you, telephone number, including area code, and e-mail address, if available.
3. Alternate contact person. Enter information for an alternate contact person, if available (same format as #2). TED will use this information to contact you, leave messages, or schedule appointments for you, if necessary.

Section 6. Professional Certification
Check the box that describes the profession of the individual signing the application form. WAC 388-818-010 states that the following individuals are authorized to certify an applicant’s eligibility:
a. A person who is licensed or certified by the department of health to provide health care in the state of Washington;
b. An audiologist or hearing aid fitter/dispenser in Washington;
c. A deaf specialist or coordinator at one of the community service centers for the deaf and hard of hearing in the state;
d. Any in-state nonprofit organization serving the hearing or speech impaired.
e. Staff from a qualified state agency;
f. A vocational rehabilitation counselor;
g. A deaf-blind specialist or coordinator at an organization that serves deaf-blind people;
h. A licensed occupational therapist;
i. Other: write-in your profession.

When you’ve completed your Application, send pages 5 - 7 to ODHH.
**Definition of Deaf-Blind for the purpose of NDBEDP.** To apply for participation in the NDBEDP, the HKNC Act defines an “individual who is deaf-blind” as any individual:

1. Who has a central visual acuity of 20/200 or less in the better eye with corrective lenses, or a field defect such that the peripheral diameter of visual field subtends an angular distance no greater than 20 degrees, or a progressive visual loss having a prognosis leading to one or both these conditions;
2. Who has a chronic hearing impairment so severe that most speech cannot be understood with optimum amplification, or a progressive hearing loss having a prognosis leading to this condition; and
3. For whom the combination of impairments described in 1 and 2 above cause extreme difficulty in attaining independence in daily life activities, achieving psychosocial adjustment, or obtaining a vocation.

**Do you (the applicant) meet the above criteria?** □ Yes □ No

### Section 1. Applicant’s Information

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<td>1. Last name, first name, middle initial</td>
<td>2. Gender</td>
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<td></td>
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<td>□ Male □ Female</td>
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<tr>
<td>3. Home address</td>
<td>City</td>
<td>State Zip Code</td>
</tr>
<tr>
<td>4. Mailing address (if different)</td>
<td>City</td>
<td>State Zip Code</td>
</tr>
<tr>
<td>5. Community/Facility name (i.e., nursing home, apartment complex)</td>
<td></td>
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<td>6. County</td>
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<td>7. Home phone number (include area code)</td>
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<td>□ Voice □ VP □ TTY □ FAX</td>
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<tr>
<td>8. Message phone number (include area code)</td>
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<tr>
<td>(   )</td>
<td>□ Voice □ VP □ TTY □ FAX</td>
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<tr>
<td>9. E-mail address</td>
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<tr>
<td>10. Best times to contact</td>
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<tr>
<td>11. Social Security Number (optional)</td>
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<tr>
<td>12. Date of Birth (MM/DD/YYYY)</td>
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13. **Are you of Hispanic origin?** □ Yes □ No

   The Spanish/Hispanic/Latino question is about ethnicity, not race. Please continue to answer the following question by marking one or more boxes to indicate what you consider your race to be (check all that apply):

   □ White □ Black or African American □ American Indian or Alaskan Native
   □ Native Hawaiian or Pacific Islander □ Asian □ Other race

14. **Financial information:** Annual income: $_______ Family size: ______

   **Attach proof of income. See instructions, page 3 for more information.**
### Section 2. Profile

1. **Hearing loss** (please check the box that best describes your level of hearing):
   - [ ] Deaf
   - [ ] Hard-of-hearing
   - [ ] Late deafened
   - [ ] Can understand speech

   How old were you when this level of hearing loss was noticed? ____

2. **Vision loss** (please check the box that best describes your vision):
   - [ ] Blind
   - [ ] Low vision
     - [ ] Close vision
     - [ ] Tunnel vision

   How old were you when you noticed this level of vision was noticed? ____

3. Do you have any difficulty using your hands for keyboarding, dialing the phone, or holding small objects?  [ ] Yes  [ ] No

4. **Communication preference** (check all that apply):
   - [ ] American Sign Language (ASL)
   - [ ] Pidgin Sign Language (PSE)
   - [ ] Sign Exact English (SEE)
   - [ ] High Visual Communication Skills (HVCS)/(MLS)
   - [ ] Tactile Sign Language
   - [ ] Close-Vision Sign Language
   - [ ] Spoken Language; if speak foreign language, specify:
     - [ ] International Sign Language (specify):
   - [ ] Other (specify):

5. **How do you read?** Please check all that apply
   - [ ] Regular print
   - [ ] Large print
   - [ ] Braille grade 1 (Uncontracted)
   - [ ] Computer Braille
   - [ ] Braille grade 2 (Contracted)

### Section 3. Communication Methods

1. Which of these activities do you currently perform? Please check all that apply.
   - [ ] TTY calls by landline telephone
   - [ ] TTY calls by web/computer
   - [ ] TTY calls by instant messaging programs
   - [ ] Relay calls by landline telephone
   - [ ] Relay calls by web/computer
   - [ ] Relay calls by instant messaging programs

   - [ ] Videophone
   - [ ] Text messaging
   - [ ] Instant messaging
   - [ ] Email
   - [ ] Internet surfing / searching
   - [ ] Other:

2. What equipment do you use to perform the above tasks? Please check all that apply.
   - [ ] TTY
   - [ ] Video Equipment
   - [ ] DBC
   - [ ] Computer with speech screen reader
   - [ ] Computer with Braille display
   - [ ] iPad or other tablet device
   - [ ] iPhone or other smart phone

3. Do you have an Internet connection in your home that you can use?  [ ] Yes  [ ] No
## Section 4. Program Goals
What is your communication goal through participation in the NDBEDP?

## Section 5. Client Signature

<table>
<thead>
<tr>
<th>1. Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Person completing application (if other than applicant)</td>
<td>3. Alternate contact person (for applicant)</td>
</tr>
<tr>
<td>Name</td>
<td>Relationship</td>
</tr>
<tr>
<td>Telephone number (include area code)</td>
<td>Telephone number (include area code)</td>
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<tr>
<td>Email address</td>
<td>Email address</td>
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</tbody>
</table>

## Section 6. Professional Certification

Professional must sign the application.

By signing below, you certify you have direct knowledge that the applicant’s disability meets the following definition of Deaf-Blind.

**Definition of Deaf-Blind for the purpose of NDBEDP.** To apply for participation in the NDBEDP, the HKNC Act defines an “individual who is deaf-blind” as any individual:

1. Who has a central visual acuity of 20/200 or less in the better eye with corrective lenses, or a field defect such that the peripheral diameter of visual field subtends an angular distance no greater than 20 degrees, or a progressive visual loss having a prognosis leading to one or both these conditions;
2. Who has a chronic hearing impairment so severe that most speech cannot be understood with optimum amplification, or a progressive hearing loss having a prognosis leading to this condition; and
3. For whom the combination of impairments described in 1 and 2 above cause extreme difficulty in attaining independence in daily life activities, achieving psychosocial adjustment, or obtaining a vocation.

<table>
<thead>
<tr>
<th>1. Professional information:</th>
<th>2. Professional signature</th>
<th>Date</th>
<th>Printed Name and title</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Doctor</td>
<td>☐ Deaf Specialist</td>
<td>☐ State Agency Employee</td>
<td>☐ Deaf-Blind Specialist</td>
</tr>
<tr>
<td>☐ Audiologist</td>
<td>☐ Non-Profit Rep</td>
<td>☐ Voc Rehab Counselor</td>
<td>☐ Occupational Therapist</td>
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<tr>
<td>☐ Other:</td>
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<thead>
<tr>
<th>Mailing address</th>
<th>E-mail address</th>
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<tbody>
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<td>Telephone number (include area code)</td>
<td>License/certificate number</td>
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<tr>
<td>( )</td>
<td>☐ Voice</td>
</tr>
<tr>
<td>☐ TTY</td>
<td>☐ FAX</td>
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