iCanConnectPA —The National Deaf-Blind Equipment Distribution Program (NDBEDP) in Pennsylvania

Application Section 1 of 3: Instructions and Guidelines

Overview

The National Deaf-Blind Equipment Distribution Program (NDBEDP) supports local programs that distribute equipment to low-income individuals who are deaf-blind (have combined hearing and vision loss) to enable access to telephone, advanced communications, and information services. This support was mandated by the Twenty-First Century Communications and Video Accessibility Act of 2010 (CVAA) and is provided by the Federal Communications Commission (FCC). For more information about the NDBEDP, please visit http://icanconnect.org or http://www.fcc.gov/ndbedp.

What is iCanConnectPA?

The Institute on Disabilities at Temple University is the certifying entity in Pennsylvania for iCanConnect. iCanConnectPA is the name of the program in Pennsylvania.

Who is Eligible to Receive Equipment?

Under the CVAA, only low-income individuals who are deaf-blind are eligible to receive equipment provided through the NDBEDP. Applicants must provide verification of their status as low-income and deaf-blind.

Income Eligibility

To be eligible, your total family/household income must be below 400% of the Federal Poverty Guidelines, as shown in the following table:

2026 Income Guidelines

(Source: U.S. Department of Health and Human Services)

Number of persons in family/household	400% for everywhere, except Alaska and Hawaii
1	$63,840
2	$86,560
3	$109,280
4	$132,000
5	$154,720
6	$177,440
7	$200,160
8	$222,880
For each additional person, add $22,720	

“Income” is all income actually received by all members of a household. This includes salary before deductions for taxes, public assistance benefits, social security payments, pensions, unemployment compensation, veteran's benefits, inheritances, alimony, child support payments, worker's compensation benefits, gifts, lottery winnings, and the like. The only exceptions are student financial aid, military housing and cost-of-living allowances, irregular income from occasional small jobs such as baby-sitting or lawn mowing, and the like.

A “household” is any individual or group of individuals who are living together at the same address as one economic unit. A household may include related and unrelated persons. An “economic unit” consists of all adult individuals contributing to and sharing in the income and expenses of a household. An adult is any person eighteen years or older. If an adult has no or minimal income, and lives with someone who provides financial support to him/her, both people shall be considered part of the same household. Children under the age of eighteen living with their parents or guardians are considered to be part of the same household as their parents or guardians.

See Section 2 for the family/household income information that must be provided with this application: either 1) proof of your current participation in a federal low-income program whose income limit is below 400% of the Federal Poverty Guidelines, or 2) proof of household income.

Disability Eligibility

For this program, the CVAA requires that the term "deaf-blind" has the same meaning given by the Helen Keller National Center Act. In general, the individual must have a certain vision loss and a hearing loss that, combined, cause extreme difficulty in attaining independence in daily life activities, achieving psychosocial adjustment, or obtaining a vocation (working).

Specifically, the FCC's NDBEDP rule 64.6203(c) states that an individual who is "deaf-blind" is:

(1) Any individual:
   i) 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;
   ii) 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
   iii) Whom the combination of impairments described in . . . (i) and (ii) of this section cause extreme difficulty in attaining independence in daily life activities, achieving psychosocial adjustment, or obtaining a vocation.

(2) An individual's functional abilities with respect to using Telecommunications service, Internet access service, and advanced communications services, including interexchange services and advanced telecommunications and information services in various environments shall be considered when determining whether the individual is deaf-blind under . . . (ii) and (iii) of this section.

(3) The definition in this paragraph (c) also includes any individual who, despite the inability to be measured accurately for hearing and vision loss due to cognitive or behavioral constraints, or both, can be determined through functional and performance assessment to have severe hearing and visual disabilities that cause extreme difficulty in attaining independence in daily life activities, achieving psychosocial adjustment, or obtaining vocational objectives.

Who Can Verify My Disability?

An applicant's disability eligibility for the program must be verified by a practicing professional who has direct knowledge of the person's vision and hearing loss, such as:

- Audiologist
- Community-based service provider
- Educator
- HKNC representative
- Medical/health professional
- Specialist in Deaf-Blindness
- Speech pathologist
- School for the deaf and/or blind
- State equipment/assistive technology program
- Hearing professional
- Vision professional
- Vocational rehabilitation counselor

Such professionals may also include, in the attestation, information about the individual's functional abilities to use telecommunications, Internet access, and advanced communications services in various settings.

Existing documentation that a person is deaf-blind, such as an individualized education program (IEP) or a Social Security determination letter, may serve as verification of disability.

See Section 3 for the disability attestation information that must be provided with this application.

What Kind of Equipment Can I Receive?

You may be eligible to receive equipment that enables you to make a phone call, send an email, access the Internet or use other communications technology so you can communicate with family, friends, community members, etc.

How Do I Apply?

Fill out the forms included in this packet. Mail the forms, along with copies of documents needed for proof of income, to the address on the last page of the application form.

How Do I Know What Equipment I Need?

If you are eligible, you will be contacted to schedule an equipment assessment. After the assessment, equipment will be ordered for you.

Confidentiality Policy

iCanConnect is committed to ensuring that your privacy is protected. Information provided on this application form will only be used to determine eligibility for iCanConnect products and services. iCanConnect will not sell, distribute or lease your personal information to third parties unless you give permission, or if the iCanConnect program is required by law to do so. iCanConnect is committed to ensuring that personal information is secure. In order to prevent unauthorized access or disclosure, suitable physical, electronic and managerial procedures are in place to safeguard and secure the information iCanConnect collects.

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Application Section 2 of 3: Applicant's Personal Data

(please fill in all fields)

Name of Applicant _____

Date of birth (month/day/year) _____ Gender _____

(If you are under age 18, your parent or legal guardian must sign the application.)

Street address _____

City (PA) _____ Zip Code _____

County (e.g. Allegheny, Snyder) _____

Primary phone _____ ☐Voice ☐VP ☐TTY

Alternate number _____

Email _____

Have you participated in iCanConnect (the National Deaf-Blind Equipment Distribution Program) before?

☐ Yes ☐ No

If yes, what state/states did you participate in iCanConnect? (list all)

_____

Did you previously receive equipment through iCanConnect in another state?

☐ Yes ☐ No

If yes, from what state/states did you receive equipment through iCanConnect? (list all)

_____

How many people are living in your household? _____

Language preference (check all that apply)

- ☐ ASL
- ☐ Close Vision ASL/PSE
- ☐ Tactile ASL/PSE
- ☐ English (spoken)
- ☐ No Formal Language
- ☐ Pidgin Signed English
- ☐ Signed English
- ☐ Spanish (spoken)
- ☐ Other (please specify): _____

Which format do you prefer for written correspondence?

- ☐ Braille
- ☐ Large Print
- ☐ Email
- ☐ Standard Print
- ☐ Other (please specify): _____

Prefer to be contacted by:

- ☐ Email
- ☐ Fax
- ☐ Text Message
- ☐ TTY (dial 711 for Relay)
- ☐ Phone (voice)

Name of Alternate Contact Person _____

Relationship with Applicant _____

Street Address _____

City/State/Zip Code _____

Primary Phone _____ Email _____

Feedback/Suggestions (optional):

_____

How did you hear about this program (select one)?

- ◯ iCanConnect.org website
- ◯ Friends
- ◯ Conference or Seminar
- ◯ Family Members
- ◯ Disability advocacy group
- ◯ Interpreter
- ◯ Specialist in Deaf-Blind Services
- ◯ Senior Center
- ◯ Education provider /School
- ◯ Technology vendor
- ◯ Healthcare provider
- ◯ Helen Keller National Center (HKNC) representative
- ◯ Independent Living Center
- ◯ News / Media (television, magazine, radio)
- ◯ Social Media (Facebook, Twitter)
- ◯ State Deaf-Blind Project
- ◯ Vocational Rehabilitation Counselor
- ◯ Other (please specify): _____

Person assisting applicant with this application, if any (please print clearly)

Name _____

Primary phone _____ Email_____

Full address (include city, state and zip code) _____

_____

Relationship to applicant _____

Income Eligibility

To confirm your income eligibility, please mail or fax documentation that proves one of the following:

You are currently enrolled in a federal program with an income eligibility requirement that does not exceed 400% of the Federal Poverty Guidelines, such as:

- Medicaid
- Supplemental Security Income (SSI)
- Federal public housing assistance or Section 8
- Food Stamps or Supplemental Nutrition Assistance Program (SNAP)
- Veterans and Survivors Pension Benefit; OR

Proof of all household income (as described in Section 1)

Please mail or fax a copy of last year's Federal IRS 1040 tax form(s) filed by you and members of your family/household or send other evidence of your total family/household income, such as recent Social Security Administration retirement benefit statement(s) or other pension benefit statement(s).

If none of the above applies, mail or fax a copy of the most recent W-2's and/or 1099 forms filed by you and members of your family/household or send other evidence of your total family/household income, such as recent Social Security Administration retirement benefit statement(s), or other pension benefit statement(s).

Contact iCanConnectPA if you are not sure what to send.
NOTE: Income eligibility is valid for one year.

Number of people living in your household*:

*Count yourself and include your spouse, and children age 17 or under. Also include children age 18-21 if they still have an Individualized Education Plan in school). For families/households with more than 8 persons, please contact iCanConnectPA.

Applicant's Attestation Statement

Please read the following statements, checking the boxes to confirm you agree. Please note that ***your signature is also required*** to complete this section.

☐ I certify that all information provided on this application, including information about my disability and total household income, is true, complete, and accurate to the best of my knowledge. I authorize program representatives to verify the information provided.

☐ I permit information about me (applicant name) _____ to be shared with my state's current and successor program managers and representatives for the administration of the program and for the delivery of equipment and services to me. I also permit information about me to be reported to the Federal Communications Commission for the administration, operation, and oversight of the program.

☐ If I am accepted into the program, I agree to use program services solely for the purposes intended. I understand that I may not sell, give, or lend to another person any equipment provided to me by the program.

☐ If I provide false records or fail to comply with these or other requirements or conditions of the program, program officials may end services to me immediately. Also, if I violate these or other requirements or conditions of the program on purpose, program officials may take legal action against me.

☐ I certify that I have read, understand, and accept these conditions to participate in iCanConnectPA (the National Deaf-Blind Equipment Distribution Program in Pennsylvania).

Print name of applicant or parent/guardian (if applicant is under age 18):

_____

Signature _____ Date _____

If this application is completed by someone other than the applicant, please state your name.

_____

By affixing my name above, I certify that I am signing this application for the applicant and with the applicant's knowledge and consent.

Privacy Statement

The Federal Communications Commission (FCC) collects personal information about individuals through the National Deaf-Blind Equipment Distribution Program (NDBEDP), a program also known as iCanConnect. The FCC will use this information to administer and manage the NDBEDP.

Personal information is provided voluntarily by individuals who request equipment (NDBEDP applicants) and individuals who attest to the disability of NDBEDP applicants.This information is needed to determine whether an applicant is eligible to participate in the NDBEDP. In addition, personal information is provided voluntarily by individuals who file NDBEDP-related complaints with the FCC on behalf of themselves or others.When this information is not provided, it may be impossible to resolve the complaints. Finally, each state's NDBEDP-certified equipment distribution program must submit to the FCC certain personal information that it obtained through its NDBEDP activities.This information is required to maintain each state's certification to participate in this program.

The FCC is authorized to collect the personal information that is requested through the NDBEDP under sections 1, 4, and 719 of the Communications Act of 1934, as amended; 47 U.S.C. 151, 154, and 620.

The FCC may disclose the information collected through the NDBEDP as permitted under the Privacy Act and as described in the FCC's Privacy Act System of Records Notice at 77 FR 2721 (Jan. 19, 2012), FCC/CGB-3, "National Deaf-Blind Equipment Distribution Program (NDBEDP)," https://www.fcc.gov/omd/privacyact/documents/records/FCC-CGB-3.pdf.

This statement is required by the Privacy Act of 1974, Public Law 93-579, 5 U.S.C. 552a(e)(3).

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Section 3 of 3: Verification of Disability

This disability verification section is to be completed by a practicing professional who has direct knowledge of the applicant's vision and hearing loss.

Please fill out this form completely, and sign and date at the bottom.

Name and Address of Deaf-Blind Individual

Name of Applicant _____

Street Address _____

City _____, PA Zip _____

Attester Information

Name of Attester _____ Title _____

Agency/Employer _____

Email _____ Phone _____

Street Address _____

City / State / Zip Code _____

Occupation (required):

☐ Audiologist
☐ Vocational Rehab Counselor
☐ Medical/Health Professional
☐ Speech-Language Pathologist
☐ Educator
☐ Community-Based Service Provider

☐ Hearing Professional
☐ Representative, School for the Deaf or Blind
☐ Vision Professional
☐ HKNC representative
☐ Other (please explain):

For this program, the CVAA requires that the term “deaf-blind” has the same meaning given by the Helen Keller National Center Act. In general, the individual must have a certain vision loss and a hearing loss that, combined, cause extreme difficulty in attaining independence in daily life activities, achieving psychosocial adjustment, or obtaining a vocation (working).

Specifically, the FCC’s NDBEDP rule 64.6203(c) states that an individual who is “deaf-blind” is:

(1) Any individual:
  (i) 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;
  (ii) 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
  (iii) For whom the combination of impairments described in . . .(i) and (ii) of this section cause extreme difficulty in attaining independence in daily life activities, achieving psychosocial adjustment, or obtaining a vocation.
(2) An individual’s functional abilities with respect to using Telecommunications service, Internet access service, and advanced communications services, including interexchange services and advanced telecommunications and information services in various environments shall be considered when determining whether the individual is deaf-blind under….(ii) and (iii) or this section.
(3) The definition in this paragraph (c) also includes any individual who, despite the inability to be measured accurately for hearing and vision loss due to cognitive or behavioral constraints, or both, can be determined through functional and performance assessment to have severe hearing and visual disabilities that cause extreme difficulty in attaining independence in daily life activities, achieving psychosocial adjustment, or obtaining vocational objectives.

I certify under penalty of perjury that, to the best of my knowledge, this individual is deaf-blind as defined by the FCC as above (and as previously referenced in Section 1).

My attestation is based on the following (Please state how you are familiar with each of the applicant's hearing and vision loss, AND the applicant's combination of hearing and vision loss, as defined in the FCC's NDBEDP rules listed directly above):

Combination of hearing and vision loss

_____

Hearing loss

_____

Vision loss

_____

Attester Signature _____ **Date** _____

Please submit this completed document and any required supporting materials to us by mail, fax, or email to:

Institute on Disabilities at Temple University
College of Education and Human Development
Attn: iCanConnectPA
Ritter Annex 4 | Room RA 430
1301 Cecil B. Moore Avenue
Philadelphia, PA 19122
Voice: 800-204-7428
TTY: 711
Fax: 215-204-6336
Email: iCanConnectPA@temple.edu

FINAL CHECKLIST

Your application is not complete until we have received:

- ☐ Application (*Section 2*) (ALL sections must be completed)
- ☐ Verification of Disability (*Section 3*)
- ☐ Income Eligibility—Include Proof of Enrollment for a least one of the listed programs OR Proof of Household Incomes

Please submit this completed document and any required supporting materials to us by mail, fax, or email:

Institute on Disabilities at Temple University
College of Education and Human Development
Attn: iCanConnectPA
Ritter Annex 4 | Room RA 430
1301 Cecil B. Moore Avenue
Philadelphia, PA 19122

Fax: 215-204-6336
Email: iCanConnectPA@temple.edu

For more information, contact:

Voice: 800-204-7428
TTY: 711
Fax: 215-204-6336
Email: iCanConnectPA@temple.edu

The Institute on Disabilities at Temple University, College of Education is Pennsylvania's certifying program for iCanConnect – National Deaf-Blind Equipment Distribution Program.