



# National Deaf-Blind Equipment Distribution Program Application

When you have completed the application,  
**mail pages 6 – 8 to:** ODHH - NDBEDP  
 PO Box 45301  
 Olympia, WA 98504-5301

## OFFICE USE ONLY

Date Received

Print or type clearly.

### Section 1. Applicant's Information

1. Last name, first name, middle initial		2. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
3. Home address	City	State	Zip Code
4. Mailing address (if different)	City	State	Zip Code
5. Community/Facility name (i.e., nursing home, apartment complex)		6. County	
7. Home phone number (include area code) ( ) <input type="checkbox"/> Voice <input type="checkbox"/> VP <input type="checkbox"/> TTY <input type="checkbox"/> FAX		8. Message phone number (include area code) ( ) <input type="checkbox"/> Voice <input type="checkbox"/> VP <input type="checkbox"/> TTY <input type="checkbox"/> FAX	
9. E-mail address		10. Best times to contact	
11. Social Security Number (optional)		12. Date of Birth (MM/DD/YYYY)	

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. Federal Program Participation. Do you receive any of the following:

Medicaid  
 Low income home energy assistance  
 SSI / SSDI  
 Federal public housing or Section 8  
 Food Stamps or Supplemental Nutrition Assistance (SNAP)  
 Temporary Assistance for Needy Families Program or Welfare to Work (TANF or WTW)

15. Income Eligibility: Annual income: \$ \_\_\_\_\_ Household 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 If yes, please explain:

4. Communication preference (check all that apply):

- |  |  |
|--|--|
| <input type="checkbox"/> American Sign Language (ASL)                  | <input type="checkbox"/> Spoken Language; if speak foreign language, specify:<br>_____ |
| <input type="checkbox"/> Pidgin Sign Language (PSE)                    | <input type="checkbox"/> International Sign Language (specify):<br>_____               |
| <input type="checkbox"/> Sign Exact English (SEE)                      | <input type="checkbox"/> Other (specify):<br>_____                                     |
| <input type="checkbox"/> High Visual Communication Skills (HVCS)/(MLS) |  |
| <input type="checkbox"/> Tactile Sign Language                         |  |
| <input type="checkbox"/> Close-Vision Sign Language                    |  |

5. How do you read? Please check all that apply

- Regular print                       Braille grade 1 (Uncontracted)                       Computer Braille  
 Large print                       Braille grade 2 (Contracted)

### Section 3. Communication Methods

1. Which of these activities do you currently perform? Please check all that apply.

- |  |   |
|--|---|
| <input type="checkbox"/> TTY calls by landline telephone           | <input type="checkbox"/> Videophone                   |
| <input type="checkbox"/> TTY calls by web/computer                 | <input type="checkbox"/> Text messaging               |
| <input type="checkbox"/> TTY calls by instant messaging programs   | <input type="checkbox"/> Instant messaging            |
| <input type="checkbox"/> Relay calls by landline telephone         | <input type="checkbox"/> Email                        |
| <input type="checkbox"/> Relay calls by web/computer               | <input type="checkbox"/> Internet surfing / searching |
| <input type="checkbox"/> Relay calls by instant messaging programs | <input type="checkbox"/> Other:                       |

2. What equipment do you use to perform the above tasks? Please check all that apply.

- |   |   |
|---|---|
| <input type="checkbox"/> TTY                                | <input type="checkbox"/> Computer with speech screen reader |
| <input type="checkbox"/> Video Equipment                    | <input type="checkbox"/> Computer with Braille display      |
| <input type="checkbox"/> DBC                                | <input type="checkbox"/> iPad or other tablet device        |
| <input type="checkbox"/> Computer with screen magnification | <input type="checkbox"/> 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

1. Signature

Date

2. Person completing application (if other than applicant)

Name

Relationship

3. Alternate contact person (for applicant)

Name

Relationship

Telephone number (include area code)

( )

Voice  VP  
 TTY  FAX

Telephone number (include area code)

( )

Voice  VP  
 TTY  FAX

Email address

Email address

## 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.

1. Professional information:

Doctor       Deaf Specialist       State Agency Employee       Deaf-Blind Specialist  
 Audiologist       Non-Profit Rep       Voc Rehab Counselor       Occupational Therapist  
 Other:

2. Professional signature

Date

Printed Name and title

Mailing address

E-mail address

Telephone number (include area code)

( )

Voice  VP  
 TTY  FAX

License/certificate number