



# Telecommunication Equipment Distribution (TED) Program

## APPLICANT INFORMATION

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_

Street Address: \_\_\_\_\_ City/St/Zip: \_\_\_\_\_

County of Residence: \_\_\_\_\_ Email Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_

\*Gender:  Male  Female

\*Race:  White  Black  Native American  Hispanic  Asian American  Other

\* Starred questions are optional at the discretion of the applicant. This information is used by the department for demographic program reviews.

Who else can we contact in order to reach you?

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

How did you hear about this program? \_\_\_\_\_

## ELIGIBILITY

To be eligible for the TED program the individual must meet the following criteria:

Are you a resident of the state of South Dakota?  Yes  No

Do you have access to telecommunication service?  Yes  No

Specify type of telecommunication service that will be used (ex: home phone service, cellular, internet, etc):

\_\_\_\_\_

## DISABILITY

**Check which disability group best defines applicant's disability:**

Deaf (*Profound Hearing Loss – 90 dB or more in better ear*)

Hard of Hearing (*30 dB or more in better ear*)

Speech Impairment

I wear hearing aid(s) (*Certificate of Impairment not required*)

I have a Cochlear Implant (*Certificate of Impairment not required*)

Blind or Visually Impaired with Hearing Loss

**COMMUNICATION**

Preferred Mode of Communication

Voice     ASL     Email     VRS     IP Relay     Texting

**INCOME ELIGIBILITY**

**\*Note:** Complete only if receiving a device over \$250. Most of the amplified phones fall under the \$250 threshold; TTYs are exempt from income eligibility; income guidelines apply to all iDevices.

Income - Income eligibility is based on the most recent Federal Poverty Guidelines at or below 300% of the federal poverty level and includes gross household income. Income includes gross wages, public assistance benefits, social security payments, pensions and unemployment compensation.

**Total Number of members in household:** \_\_\_\_\_

Type of Income	Annual Amount
Gross wages	
Self-Employment	
Social Security, SSI or SSDI	
Pensions	
Public Assistance	
Unemployment/ Worker’s Compensation	
TOTAL	

2014 Federal Poverty Guidelines	
Family Size	300%
1	\$35,010
2	\$47,190
3	\$59,370
4	\$71,550
5	\$83,730
6	\$95,910
7	\$108,090
8	\$120,270

**Accepted forms of income include:**

Income or wage statements (examples include pay statements, social security, unemployment, public assistance, or other statements verifying money received by the family. Include at least three consecutive statements with this application.) or most recent federal tax form (1040 Tax Return).

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

*By signing, I affirm that the information provided is complete and correct to the best of my knowledge.*

<p><b>Program Administration</b>                  South Dakota Division of Rehabilitation Services                  c/o Deaf Program Specialist                  500 East Capitol                  Pierre, SD 57501                  1-800-265-9684 (toll free)                  605-773-5990 (voice)                  605-773-6412 (TTY)</p>	<p>Return this form to:  <b>CSD of Rapid City</b>  <b>2040 W. Main Street, Suite #306,</b>  <b>Rapid City, SD 57702</b>  <b>(605) 394-6864 (V/TTY)</b>  <b>(888) 304-2311 (V/TTY)</b>  <b>(605) 394-6609 (fax)</b></p>
---	--

**This program is funded through South Dakota Department of Human Services (DHS)  
 Services are provided by DHS and CSD**



## Certification of Hearing / Speech / Visual Impairment for Telecommunication Equipment Distribution (TED) Program

### APPLICANT INFORMATION

Name: \_\_\_\_\_

Street Address: \_\_\_\_\_ City/St/Zip: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_

**This certification can be completed by one of the following:**

- Audiologist or Hearing Instrument Specialist
- Licensed Physician
- Department of Human Services
  - Division of Vocational Rehabilitation
  - Division of Service to the Blind and Visually Impaired
- Speech-Language Pathologist

An examination of our records show that the applicant has a hearing loss which causes an impediment in accessing telecommunication services. For consideration of hearing loss, please use the average for the frequencies of 500, 1000, and 2000 Hz in the better ear.

Deaf: Profound Hearing loss _____ (90 dB or more in better ear)	Hard of Hearing _____ (30 dB or more in better ear)
Speech Impairment _____	Blind or Visually Impaired with hearing loss _____

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Agency: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Signature \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Return this form to:**  
**CSD of Rapid City**  
**2040 W. Main Street, Suite #306,**  
**Rapid City, SD 57702**  
**(605) 394-6864 (V/TTY)**  
**(888) 304-2311 (V/TTY)**  
**(605) 394-6609 (fax)**

**This program is funded through South Dakota Department of Human Services (DHS)  
Services are Provided by DHS and CSD**