



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	

2015 Federal Poverty Guidelines	
Family Size	300%
1	\$35,310
2	\$47,790
3	\$60,270
4	\$72,750
5	\$85,230
6	\$97,710
7	\$110,190
8	\$122,670

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>Program Administration 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: CSD of Sioux Falls 3520 S. Gateway Lane Sioux Falls, SD 57106 (866) 246-5759 (V/TTY) (605)-593-9392 (V/TTY)</p>
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If found eligible for an iPhone or iPad please specify where to ship the device	
Ship Device to Applicant _____	Ship Device to CSD _____

**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 Sioux Falls
3520 S. Gateway Lane
Sioux Falls, SD 57106
(866) 246-5759 (V/TTY)
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