Application for Telecommunication Equipment Distribution (TED) Program

www.relaysd.com | (605) 362-2912 | (866) 246-5759

Applicant Name: _____

Physical Address: _____

Mailing Address (if different): _____

City/State/Zip: _____

County of Residence: _____ Email: _____

Primary Phone: _____ Home | Mobile | Text Only | VP

Secondary Phone: _____ Home | Mobile | Text Only | VP

Date of Birth: _____/_____/_____ Age: _____ Gender: Male ____ Female ____

Race: Caucasian ____ | Native American ____ | Hispanic ____ | Asian American ____ | African American ____ | Other: _____

Directions to your residence: _____

_____

Who else can we contact to reach you? _____ Phone: _____

How did you hear about this program? (all that apply)

___ Previous Applicant ___ Family/Friend ___ Booth Event ___ Internet Search

___ Medical Professional ___ Media/TV ___ CSD Staff ___ Other: _____

Preferred mode(s) of communication (all that apply): __Voice __Email __ASL __VRS __Text __IPRelay

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

_____ _____ _____

Date Applicant's Signature Guardian or Parent (if applicable)

Office Use Only: Date Application Received: _____ Date of Renewed Contact: _____

PROGRAM ELIGIBILITY

Access to telecommunication services: ___Landline ___Internet ___Cell Service ___Other: _____

EQUIPMENT REQUESTED

___Amplified Cordless Phone ___Caption Phone (corded) ___Corded Phone/Large buttons ___Other:_____

Please check all that apply:

_____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 and not eligible for iCanConnectSD

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

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

INCOME ELIGIBILITY

*Note: Complete only if applying for a device over $500. Most of the amplified phones fall under the $500 threshold. TTY's are exempt from income eligibility. Income guidelines apply to all iDevices. See table below for qualifying income at 400%.

Total Number of Members in Household: _____

Complete the table below with income information including ALL members of the household.

Type of Income	Annual Amount		2023 Federal Poverty Guidelines	
Gross Wages	$		**Family Size**	**400%**
Self-Employment	$		**1**	**$58,320**
Social Security, SSI or SSDI	$		**2**	**$78,880**
Pensions	$		**3**	**$99,440**
Public Assistance	$		**4**	**$120,000**
Unemployment/Worker's Compensation	$		**5**	**$140,560**
			6	**$161,120**
			7	**$181,680**
TOTAL	$		**8**	**$202,240**

Accepted forms of income include:

*****Income or wage statements including: pay statements, social security, unemployment, Public assistance or other statements verifying money received by the family. Include at least 3 consecutive statements with this application. Most recent federal tax form (1040 Tax Return)

Return this form to:
CSD of Sioux Falls
524 N Sycamore Ave, STE 2
Sioux Falls, SD 57110
866-246-5759 (Toll Free)
605-362-2912 (V/TTY)
605-394-6609 (Fax)

Program Administration:
South Dakota Division of Rehabilitation Services
1310 Main Ave S, Suite 102
Brookings, SD 57006
800-265-9679 (Toll Free)
605-688-4224 (V/TTY)
605-688-5497 (Fax)

Office use only: if found eligible for an iDevice, ship to: _____ Applicant _____CSD Office

Certification of Hearing/Speech Status for Telecommunication Equipment Distribution (TED) Program

Applicant Name: _____

Address/City/State: _____

This certification can be completed by one of the following:

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

An examination of our records shows 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 of more in better ear

_____ Hard of Hearing
30dB or more in better ear

____ Speech Impairment

_____ Blind or Visually Impaired with hearing loss
doesn't meet criteria for iCanConnectSD

Certifier Name: _____ Title: _____

Agency: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

I attest that I am eligible to certify under the provisions of the law. I am aware of the extent of the applicant's hearing status that is consistent with the requirements of the program. The applicant can benefit from specialized telecommunication equipment.

_____ _____

Signature of Certifier Date

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