



Questions? Call CSD (605) 362-2912 (V/TTY) or toll free (866) 246-5759

Application for Telecommunication Equipment Distribution Program www.relaysd.com

Name: _____

Address: _____

Mailing address: _____

City | State | Zip: _____

County of Residence: _____ Email: _____

Best Contact Phone: (____) _____ Home | Mobile | Text Only | Videophone

Other Phone: (____) _____ Home | Mobile | Text Only | Videophone

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

Race: ____ White | ____ Native American | ____ Hispanic | ____ Asian American

____ African American | Other: _____

Directions to your residence from a landmark or nearby town: _____

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

How did you hear about this program? _____

How do you access telecommunication services? Landline | Internet | Cellular Service | Other: _____

Preferred mode(s) of communication: ____ Voice | ____ Email | ____ ASL | ____ VRS | ____ Text | ____ IP Relay

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)

PHYSICAL ELIGIBILITY

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

 I wear hearing aid(s) (*Certificate of Impairment not required*)
 I have a Cochlear Implant (*Certificate of Impairment not required*)

INCOME ELIGIBILITY --- ONLY FOR APPLICATIONS FOR iDevices ---

*Note: Complete only if applying for a device over \$250. Most of the amplified phones fall Under the \$250 threshold. TTY's are exempt from income eligibility. Income guidelines apply to all iDevices. See table below for qualifying income at 300%.

Total Number of people in household: _____

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

Type of Income	Annual Amount	2017 Federal Poverty Guidelines	
		Family Size	300%
Gross Wages	\$	1	36,180.00
Self-Employment	\$	2	48,720.00
Social Security, SSI or SSDI	\$	3	61,260.00
Pensions	\$	4	73,800.00
Public Assistance	\$	5	86,340.00
Unemployment/Worker's Compensation	\$	6	98,880.00
		7	111,420.00
TOTAL	\$	8	123,960.00

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)

Program Administration:

South Dakota Division of Rehabilitation Services
 c/o Deaf Program Specialist
 811 E 10th St Dept 21
 Sioux Falls, SD 57103
 800-265-9679 (toll free)
 605-367-4657 (voice or TDD)

Return this form to:

CSD of Sioux Falls
 117 W 39th Street
 Sioux Falls, SD 57105
 866-246-5759 (toll free)
 605-362-2912 (voice/TTY)



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
- 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 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:

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Sioux Falls, SD 57105
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**This program is funded through South Dakota Department of Human Services (DHS)
Services are provided by DHS and CSD**