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)**

Office Use Only: Date Application Received: _____

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
Gross wages	$
Self-Employment	$
Social Security, SSI or SSDI	$
Pensions	$
Public Assistance	$
Unemployment/ Worker's Compensation	$
TOTAL	$

2016 Federal Poverty Guidelines	
Family Size	300%
1	$35,640
2	$48,060
3	$60,480
4	$72,900
5	$85,320
6	$97,740
7	$110,190
8	$122,670

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
500 East Capitol
Pierre, SD 57501
800-265-9684 (toll free)
605-773-5990 (voice)
605-773-6412 (TTY)

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)

Office Use only: If found eligible for an iDevice, ship to: _____ Applicant _____Office

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
- Department of Human Services
  - Division of Vocational Rehabilitation
  - Division of Service to the Blind and Visually Impaired
- Licensed Physician
- 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
117 W 39th Street
Sioux Falls, SD 57105
866-246-5759 (toll free)
605-362-2912 (voice/TTY)

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