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		2017 Federal Poverty Guidelines	
Gross Wages	$		**Family Size**	**300%**
Self-Employment	$		**1**	36,180.00
Social Security, SSI or SSDI	$		**2**	48,720.00
Pensions	$		**3**	61,260.00
Public Assistance	$		**4**	73,800.00
Unemployment/Worker's Compensation	$		**5**	86,340.00
			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 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 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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This program is funded through South Dakota Department of Human Services (DHS)
Services are provided by DHS and CSD