



**Application for Telecommunication Equipment Distribution (TED) Program**

[www.relaysd.com](http://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: \_\_\_\_\_

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 --- Only for Applications Requesting 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 Members in Household: \_\_\_\_\_

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

Type of Income	Annual Amount	2019 Federal Poverty Guidelines	
		Family Size	300%
Gross Wages	\$	1	\$37,470
Self-Employment	\$	2	\$50,730
Social Security, SSI or SSDI	\$	3	\$63,990
Pensions	\$	4	\$77,250
Public Assistance	\$	5	\$90,510
Unemployment/Worker's Compensation	\$	6	\$103,770
		7	\$117,030
TOTAL	\$	8	\$130,290

### 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  
117 W 39<sup>th</sup> Street  
Sioux Falls, SD 57105  
866-246-5759 (Toll Free)  
605-362-2912 (V/TTY)  
605-394-6609 (Fax)

#### Program Administration:

South Dakota Division of Rehabilitation Services  
c/o Deaf Program Specialist 811 E 10<sup>th</sup> St Dept 21  
Sioux Falls, SD 57103  
800-265-9679 (Toll Free)  
605-367-4657 (V/TTY)  
605-367-5327 (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 or 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.**