Questions? Call CSD (605) 394-6864 (v/TTY) or toll free (888) 304-2311

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: ______________ Date of Renewed Contact:______________

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		2018 Federal Poverty Guidelines	
Gross Wages	$		**Family Size**	**300%**
Self-Employment	$		**1**	**$36,420**
Social Security, SSI or SSDI	$		**2**	**$49,380**
Pensions	$		**3**	**$62,340**
Public Assistance	$		**4**	**$75,300**
Unemployment/Worker's Compensation	$		**5**	**$88,260**
			6	**$101,220**
			7	**$114,180**
TOTAL	$		**8**	**$127,140**

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 Rapid City
2040 W Main St, Suite #306
Rapid City, SD 57702
888-304-2311 (toll free)
605-394-6864 (V/TTY)
605-394-6609 (fax)

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
- 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:_____/______/______

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