Washington State Department of Social & Health Services
ODHH Office of the Deaf and Hard of Hearing

Print or type clearly.

National Deaf-Blind Equipment Distribution Program Application

When you have completed the application,
mail pages 10 - 18 to: ODHH - NDBEDP
PO Box 45301
Olympia, WA 98504-5301

OFFICE USE ONLY
Date Received

Section 1. Applicant's Information

1. Last name, first name, middle initial

2. Gender
   ☐ Male ☐ Female

3. Home address | City | State | Zip Code

4. Mailing address (if different) | City | State | Zip Code

5. Community/Facility name (i.e., nursing home, apartment complex)

6. County

7. Home phone number (include area code)

( ) ☐ Voice ☐ VP ☐ TTY ☐ FAX

8. Message phone number (include area code)

( ) ☐ Voice ☐ VP ☐ TTY ☐ FAX

9. E-mail address

10. Best times to contact

11. Social Security Number (optional)

12. Date of Birth (MM/DD/YYYY)

13. Are you of Hispanic origin?

☐ Yes ☐ No

The Spanish/Hispanic/Latino question is about ethnicity, not race. Please continue to answer the following question by marking one or more boxes to indicate what you consider your race to be (check all that apply):

☐ White
☐ Black or African American
☐ American Indian or Alaskan Native
☐ Native Hawaiian or Pacific Islander
☐ Asian
☐ Other race

14. Federal Program Participation. Do you receive any of the following:

- ☐ Medicaid
- ☐ Low income home energy assistance
- ☐ SSI / SSDI
- ☐ Federal public housing or Section 8
- ☐ Food Stamps or Supplemental Nutrition Assistance (SNAP)
- ☐ Temporary Assistance for Needy Families Program or Welfare to Work (TANF or WTW)

15. Income Eligibility:

Annual income: $_____

Household size: _____

Attach proof of income.

See instructions, page 5 for more information.

Section 2. Profile

1. Hearing loss (please check the box that best describes your level of hearing):

- ☐ Deaf
- ☐ Hard-of-hearing
- ☐ Late deafened
- ☐ Can understand speech

How old were you when this level of hearing loss was noticed?

_____

2. Vision loss (please check the box that best describes your vision):

- ☐ Blind
- ☐ Low vision
  - ☐ Close vision
  - ☐ Tunnel vision

How old were you when you noticed this level of vision was noticed? _____

3. Do you have any difficulty using your hands for keyboarding, dialing the phone, or holding small objects?

☐ Yes ☐ No

4. Communication preference (check all that apply):

- ☐ American Sign Language (ASL)
- ☐ Pidgin Sign Language (PSE)
- ☐ Sign Exact English (SEE)
- ☐ High Visual Communication Skills (HVCS)/(MLS)
- ☐ Tactile Sign Language
- ☐ Close-Vision Sign Language
- ☐ Spoken Language; if speak foreign language, specify:

  _____
- ☐ International Sign Language (specify):

  _____
- ☐ Other (specify):

5. How do you read? Please check all that apply

- ☐ Regular print
- ☐ Large print
- ☐ Computer Braille
- ☐ Braille grade 1 (Uncontracted)
- ☐ Braille grade 2 (Contracted)

Section 3. Communication Methods

1. Which of these activities do you currently perform? Please check all that apply.

- ☐ TTY calls by landline telephone
- ☐ Videophone
- ☐ TTY calls by web/computer
- ☐ Text messaging
- ☐ TTY calls by instant messaging programs
- ☐ Instant messaging
- ☐ Relay calls by landline telephone
- ☐ Email
- ☐ Relay calls by web/computer
- ☐ Internet surfing / searching
- ☐ Relay calls by instant messaging programs
- ☐ Other:

2. What equipment do you use to perform the above tasks? Please check all that apply.

- ☐ TTY
- ☐ Computer with speech screen reader
- ☐ Video Equipment
- ☐ Computer with Braille display
- ☐ DBC
- ☐ iPad or other tablet device
- ☐ Computer with screen magnification
- ☐ iPhone or other smart phone

3. Do you have an Internet connection in your home that you can use?

☐ Yes ☐ No

Section 4. Program Goals

What is your communication goal through participation in the NDBEDP?

Section 5. Client Signature

1. Signature

Date

2. Person completing application (if other than applicant)

Name

Relationship

Telephone number (include area code)

( ) ☐ Voice ☐ VP ☐ TTY ☐ FAX

Email address

3. Alternate contact person (for applicant)

Name

Relationship

Telephone number (include area code)

( ) ☐ Voice ☐ VP ☐ TTY ☐ FAX

Email address

Section 6. Professional Certification

Professional must sign the application.

By signing below, you certify you have direct knowledge that the applicant's disability meets the following definition of Deaf-Blind.

Definition of Deaf-Blind for the purpose of NDBEDP. To apply for participation in the NDBEDP, the HKNC Act defines an "individual who is deaf-blind" as any individual:

1. Who has a central visual acuity of 20/200 or less in the better eye with corrective lenses, or a field defect such that the peripheral diameter of visual field subtends an angular distance no greater than 20 degrees, or a progressive visual loss having a prognosis leading to one or both these conditions;
2. Who has a chronic hearing impairment so severe that most speech cannot be understood with optimum amplification, or a progressive hearing loss having a prognosis leading to this condition; and
3. For whom the combination of impairments described in 1 and 2 above cause extreme difficulty in attaining independence in daily life activities, achieving psychosocial adjustment, or obtaining a vocation.

1. Professional information:

- ☐ Doctor
- ☐ Deaf Specialist
- ☐ State Agency Employee
- ☐ Deaf-Blind Specialist
- ☐ Audiologist
- ☐ Non-Profit Rep
- ☐ Voc Rehab Counselor
- ☐ Occupational Therapist
- ☐ Other:

2. Professional signature
Date
Printed Name and title
Mailing address
E-mail address
Telephone number (include area code) ( ) ☐ Voice ☐ VP ☐ TTY ☐ FAX
License/certificate number