iKAN Connect
ATK - Kansas Deaf Blind Equipment Distribution Program
APPLICATION

This application is to request equipment that allows income eligible Kansans with combined hearing and vision loss to access modern telecommunication tools and the training, if necessary, to use them.

APPLICANT INFORMATION

Name (First, MI, Last): ______________________ __ ________________________________

Home address, City, State, Zip: ____

Mailing address, if different: ____

County: ________________________ Date of birth (01/01/1957): _____/_____/___________

Home phone number (_____)__________________ Voice VP TTY Text

Email address: ____

Preferred contact: email home phone cell work phone

Gender: Male Female

Ethnicity (optional, for federal data only):
White Black or African-American Hispanic
Native American Asian Other

Person assisting with application, if any:

Name: ____

Home phone number (____)__________ Email: _____________________

Relationship to applicant: Family Case Manager
Educator Employment Representative
Health Representative Other, specify: ________________________

APPLICANT PROFILE

1. Hearing loss (please check the box that best describes your level of hearing).
   - Deaf
   - Hard of hearing
   - Late deafened

   Can you understand speech? Yes No

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

2. Vision loss (please check the box that best describes your level of vision).
   - Blind
   - Low vision
     - Close vision Tunnel vision

   How old were you when this level of vision loss 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)
   - Conceptual Accurate Signed English (CASE)
   - Sign Exact English (SEE)
   - Tactile Sign Language

Close Vision Sign Language
Spoken Language (Please identify your primary language if you are a non-English speaker): ________________________
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)

ELIGIBILITY

I have or have applied for phone service in my home. Yes No

I have or have applied for internet service in my home. Yes No

I have the ability to access the internet (includes free local WIFI hot spots). Yes No

FINANCIAL ELIGIBILITY

Documentation of income will be needed (2 recent paystubs, SSI benefit letter, or other documents).

**201 Poverty fi±¥Ÿ¡ ˙¥ª¡ ¯ ¢«®the
48 Contiguous States and the District of Columbia**

Persons in family/household	Poverty guideline (400%)
1	$45,960
2	$62,040
3	$78,120
4	$94,200
5	$110,280
6	$126,360
7	$142,440

8	$158,520
For families/households with more than 8 persons, add $18,026 for each additional person.	

Based on the table on the previous page, I have an income that does not exceed 400% of the Federal Poverty Guidelines. Yes No

Please check if you receive government assistance under any of these programs.

Federal Public Housing Assistance, Section 8
Supplemental Nutrition Assistance Program, VISION card
Low Income Home Energy Assistance Program
Medicaid
National School Lunch Program's free lunch program
Supplemental Security Income
Temporary Assistance for Needy Families

CONSUMER GOALS

What is your communication goal through participation in iKAN Connect?

The preceding facts I have provided are true and complete to the best of my knowledge. I understand that if I provide false information, I will forfeit any equipment I received. I have read and understood all the conditions in this application and for the program.

____________________________ ____________________________

Applicant signature Date

____________________________ ____________________________

Parent or guardian signature* Date

* If the applicant is under 18 years of age, both applicant and parent/guardian must sign.

PROFESSIONAL CERTIFICATION:

Vision Status

1. Does this applicant have a visual acuity of 20/200 or less?
   Yes No

   Visual Acuity: ______________________
   (In the better eye with corrective lenses)

2. Does this applicant have a field defect of 20 degrees or less?
   Yes No

   Visual Field: _______________________

3. Does this applicant have a progressive visual loss having a prognosis leading to one or both of these conditions? Yes No

   Cause of Vision Loss: ____

Hearing Status

1. Does this applicant have a chronic hearing impairment so severe that most speech cannot be understood with optimum amplification?
   Yes No

2. Does this applicant have a progressive hearing loss having a prognosis leading to impairment so severe that most speech cannot be understood with optimum amplification?
   Yes No

   Cause of Hearing Loss: ____

Combination of Impairments

Does the combination of vision and hearing loss cause the applicant difficulty in attaining independence in daily life activities, achieving psychosocial adjustment, or obtaining a vocation? Yes No

PROFESSIONAL INFORMATION:

Low Vision Specialist Doctor Audiologist
Deaf-Blind Specialist Ophthalmologist/optometrist
Voc Rehab Counselor Other, specify: ___________________________

______________________________	______________________________
Professional signature	Date
______________________________	______________________________
Printed Name	Title
______________________________	______________________________
Mailing address	Email address
(______)________________________	______________________________
Telephone number (Voice VP TTY)	License/certificate number

If you have questions, please contact the iKAN Connect project – ATK is Kansas' authorized entity to participate in the National Deaf-Blind Equipment Distribution Program. iKAN Connect, ATK, 2601 Gabriel, Parsons, KS 67357. Call 620-421-8367; go to our website, www.atk.ku.edu, or email us at atkapps@ku.edu.

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