MISSOURI ASSISTIVE TECHNOLOGY
NATIONAL DEAF-BLIND EQUIPMENT DISTRIBUTION PROGRAM
(NDBEDP) APPLICATION
In-state: 800/647-8557(v) 800/647-8558 (tty)
Out-of-state: 816/655-6700(v) 816/655-6711 (tty)
E-mail: Brenda.Whitlock@att.net

SECTION 1 – APPLICANT INFORMATION (PLEASE PRINT CLEARLY)

Name (Last, First, Middle Initial) _____

Physical Address (Equipment is shipped UPS.) _____

City _____ **State** MO **Zip Code** _____ **County** _____

VP or TTY # _____ **Cell Phone** _____ **Home or Other Phone** _____

Social Security Number *(Required)* _____ **Date of Birth** _____

The following are requirements for requesting equipment through the NDBEDP program. If you cannot answer "yes" to all of the following and Part 2, contact MoAT to discuss a possible referral.

☐ YES ☐ NO **I am a Missouri resident.**

☐ YES ☐ NO **I have an e-mail address. E-mail (Print clearly):** _____

☐ YES ☐ NO **I have a computer with: (Check the operating system on your computer.)**
☐ Windows XP ☐ VISTA ☐ Windows 7
☐ Windows 8 ☐ MAC computer ☐ Request Computer

☐ YES ☐ NO **I have Internet service. My Internet service provider is:** _____
OR

☐ YES ☐ NO **I have a telephone line. My provider is:** _____

SECTION 2 – FINANCIAL ELIGIBILITY

☐ YES ☐ NO **I have an income that is $44,680 or less (add $15,840 for each additional person in the household)**

Attach most recent income tax form, OR documentation of enrollment in one of the following: SSI, Medicaid, Section 8 housing, Food stamps (SNAP), Medicaid, National School Free lunch program, TANF, Medicaid Waiver)

SECTION 3 – 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? _____

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

☐ Braille grade 1 (Uncontracted) ☐ Braille grade 2 (Contracted)

☐ Computer Braille ☐ Electronic/Screen Reader

SECTION 4 – COMMUNICATION METHODS

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

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

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

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

SECTION 5 – PROGRAM GOAL & REQUEST

What is your communication goal through participation in the NDBEDP?

To assist us in helping you to meet your goal and to determine what equipment will support that goal, please check all of the following that apply to you.

☐ I am requesting equipment for phone use.

☐ I am requesting equipment to access the Internet (i.e. screen reader, wireless Braille display, iPad with Braille apps, scanning software):
Please list: _____

☐ I DO NOT KNOW what type of equipment I need.

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:**

--- 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;

--- 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

--- For whom the combination of impairments described 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**
☐ **Independent Living Center** ☐ **Other:**

2. Professional signature _____ **Date** _____

Printed Name and title _____ _____

License/certificate number _____

Mailing address _____

_____

E-mail address _____

Telephone number _____

SECTION 7 – APPLICANT SIGNATURE AND INFORMATION RELEASE

The above facts are true and complete to the best of my knowledge. I authorize Missouri Assistive Technology to release my name, address, and phone number to a consumer support provider.

_____ _____

Applicant or Guardian Signature **Date**
***(Original signature required*)**

_____

Name & relationship of person completing application (if other than applicant)
Phone & email: _____

Mail completed and signed application to:
MO Assistive Technology (MoAT), NDBEDP
1501 NW Jefferson Street
Blue Springs, MO 64015

(8-2013)