



Questions? Call (800) 265-9684 (toll free), toll free (605) 773-5990 (V) or 605-773-6412 (TTY)

## Application for Telecommunication Equipment Distribution Program [www.relaysd.com](http://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)

## **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	
		Family Size	300%
Gross Wages	\$	1	\$36,420
Self-Employment	\$	2	\$49,380
Social Security, SSI or SSDI	\$	3	\$62,340
Pensions	\$	4	\$75,300
Public Assistance	\$	5	\$88,260
Unemployment/Worker's Compensation	\$	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 10<sup>th</sup> St Dept 21  
 Sioux Falls, SD 57103  
 800-265-9679 (toll free)  
 605-367-4657 (voice or TDD)

#### **Return this form to:**

SD Division of Rehabilitation Services  
 Equipment Distribution Program  
 Hillsvie Properties Plaza  
 3800 E Hwy 34, c/o 500 E Capitol  
 Pierre, SD 57501  
 800-265-9684 (toll free)  
 605-773-5990 (V)  
 605-773-6412 (TTY)

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
- Licensed Physician
- Department of Human Services
  - Division of Vocational Rehabilitation
  - Division of Service to the Blind and Visually Impaired
- 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: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Return this form to:**  
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 Equipment Distribution Program  
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 Pierre, SD 57501  
 800-265-9684 (toll free)  
 605-773-5990 (V)  
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**This program is funded through South Dakota Department of Human Services (DHS)  
 Services are provided by DHS and CSD**