
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 Braille grade 1 (Uncontracted)
 Large print Braille grade 2 (Contracted)
 Computer Braille

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. Please provide the first 2 pages of your 2016 income tax return.

2017 Poverty Guidelines for the 48 Contiguous States and the District of Columbia	
Persons in family/household	Poverty guideline (400%)
1	\$48,240
2	\$64,960
3	\$81,680
4	\$98,400
5	\$115,120
6	\$131,840

7	\$148,560
8	\$165,280
For families/households with more than 8 persons, add \$16,720 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
- Deaf-Blind Specialist
- Voc Rehab Counselor
- Doctor
- Ophthalmologist/optometrist
- Audiologist
- 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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