



Application for Telecommunication Equipment Distribution (TED) Program

www.relaysd.com | (605) 362-2912 | (866) 246-5759

Applicant Name: _____

Physical Address: _____

Mailing Address (if different): _____

City/State/Zip: _____

County of Residence: _____ **Email:** _____

Primary Phone: _____ **Home | Mobile | Text Only | VP**

Secondary Phone: _____ **Home | Mobile | Text Only | VP**

Date of Birth: ____/____/____ **Age:** ____ **Gender: Male** ____ **Female** ____

Race: Caucasian ____ **| Native American** ____ **| Hispanic** ____ **| Asian American** ____ **|**

African American ____ **| Other:** _____

Directions to your residence: _____

Who else can we contact to reach you? _____ **Phone:** _____

How did you hear about this program? (all that apply)

____ Previous Applicant ____ Family/Friend ____ Booth Event ____ Internet Search

____ Medical Professional ____ Media/TV ____ SD DROP Staff ____ Other: _____

Preferred mode(s) of communication (all that apply): ____Voice ____Email ____ASL ____VRS ____Text ____IPRelay

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)

Office Use Only: Date Application Received: _____ Date of Renewed Contact: _____

PROGRAM ELIGIBILITY

Access to telecommunication services: ___ Landline ___ Internet ___ Cell Service ___ Other: _____

EQUIPMENT REQUESTED

___ Amplified Cordless Phone ___ Caption Phone (corded) ___ Corded Phone/Large buttons ___ Amplified Corded Phone

Other: _____

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 and not eligible for iCanConnectSD
___ I wear hearing aid(s) (*Certificate of Impairment not required*)
___ I have a Cochlear Implant (*Certificate of Impairment not required*)

INCOME ELIGIBILITY

*Note: Complete only if applying for a device over \$500. Most of the amplified phones fall under the \$500 threshold. TTY's are exempt from income eligibility. Income guidelines apply to all iDevices. See table below for qualifying income at 400%.

Total Number of Members in Household: _____

Complete the table below with income information including ALL members of the household.

Type of Income	Annual Amount	2026 Federal Poverty Guidelines	
		Family Size	400%
Gross Wages	\$		
Self-Employment	\$	1	\$63,840
Social Security, SSI or SSDI	\$	2	\$86,560
Pensions	\$	3	\$109,280
Public Assistance	\$	4	\$132,000
Unemployment/Worker's Compensation	\$	5	\$154,720
		6	\$177,440
		7	\$200,160
TOTAL	\$	8	\$222,880

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)

Return this form to:

SD DROP of Sioux Falls
524 N Sycamore Ave, STE 2
Sioux Falls, SD 57110
866-246-5759 (Toll Free)
605-362-2912 (V/TTY)
605-394-6609 (Fax)

Program Administration:

South Dakota Division of Rehabilitation Services
ATTN: Hailey King
1501 S Highline Avenue Suite 1C
Sioux Falls, South Dakota 57110
605-362-3630 (Phone)
605-3675327 (Fax)

Office use only: if found eligible for an iDevice, ship to: ___ Applicant ___ SD DROP Office



Certification of Hearing/Speech Status for Telecommunication Equipment Distribution (TED) Program

Applicant Name: _____

Address/City/State: _____

This certification can be completed by one of the following:

- Audiologist or Hearing Instrument Specialist
- Department of Human Services
 - Division of Vocational Rehabilitation
 - Division of Service to the Blind and Visually Impaired
- Licensed Physician
- Speech-Language Pathologist
- SD DROP 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
30dB or more in better ear

_____ Speech Impairment

_____ Blind or Visually Impaired with hearing loss
doesn't meet criteria for iCanConnectSD

Certifier Name: _____

Title: _____

Agency: _____

Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

I attest that I am eligible to certify under the provisions of the law. I am aware of the extent of the applicant's hearing status that is consistent with the requirements of the program. The applicant can benefit from specialized telecommunication equipment.

Signature of Certifier

Date

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**This program is funded through South Dakota Department of Human Services (DHS).
Program services are provided by DHS and DR DROP.**