Support Service Provider (SSP) Program Application

Application Section 1 of 3: Guidelines

Program Description

Living independently is the ability to productively examine alternatives and make informed decisions to direct one's own life. For individuals who are deaf-blind, it can be difficult to make informed decisions due to the absence of visual and/or auditory information. The Comprehensive Service Center's (CSC) Support Service Provider Program has been designed to bridge that gap and enable its consumers who are deaf-blind to exercise their own personal choices with the freedom to make decisions affecting their daily life.

Support service providers, commonly referred to as SSPs, provide many services including, but not limited to: sighted guide services, provision of auditory/visual/environmental information in the preferred mode of communication of the consumers; access to printed material, and transportation or assistance with public transportation. The SSP does not advise, offer unsolicited opinions, or attempt to make decisions for the consumers who are deaf-blind.

For more information on SSPs, please view the Helen Keller National Center's SSP video series or contact the CSC at csc@csc-hawaii.org.

Who is eligible for the SSP program?

Individuals who are deaf-blind are eligible to receive services. Applicants must provide verification of their status as deaf-blind.

Disability Eligibility: Vision/Hearing Requirements

A. *The term "individuals who are deaf-blind" means any individual with a combined vision and hearing loss with
    a. 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 of these conditions;
    b. 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
    c. For whom the combination of impairments described in clauses (i) and (ii) cause extreme difficulty in attaining independence in daily activities, achieving psychosocial adjustment, or obtaining a vocation;
B. Who despite the inability to be measured accurately for hearing and vision loss due to cognitive or behavioral constraints, or both, can be determined through functional and performance assessment to

have severe hearing and visual disabilities that cause extreme difficulty in attaining independence in daily life activities, achieving psychosocial adjustment, or obtaining vocational objectives.

Who can attest to a person's eligibility?

A practicing professional who has direct knowledge of the person's vision and hearing loss, such as:

- Audiologist
- Community-based service provider
- Educator
- Hearing Professionals
- Helen Keller National Center representative
- Medical/health professional
- School for the deaf and blind
- Specialist in Deaf-Blindness
- Speech pathologist
- State equipment/assistive technology program
- Vision professionals
- Vocational rehabilitation counselor

Existing documentation that a person is deaf-blind such as an individualized education plan (IEP) or a Social Security determination letter, may serve as verification of disability.

Confidentiality Policy

The information provided on this application form will only be used to determine eligibility for the Support Service Provider Program and will not be shared with other agencies unless specifically directed to do so by the consumer.

Application Section 2 of 3: Applicant's Personal Data

Contact Information

Name of Applicant: ____

Date of Birth: __________________________ Gender: ____________________

Street Address: ____

City: ______________________________ Zip Code: ____________________

Mailing Address: (if different from above) ____________________________

City: ______________________________ Zip Code: ____________________

Primary Phone: __________________________ □ home □ mobile □ text □ VP

Alternate Phone: __________________________ □ home □ mobile □ text □ VP

Email: ____

What is the best way to contact you? □ phone voice □ phone text □ email

Description of Hearing Loss

Please describe your hearing:

Description of Vision Loss

Please describe your vision:

Please select any that apply to your vision:

- ☐ Low Vision/Visually Impaired
- ☐ Tunnel Vision/RP
- ☐ Blind
- ☐ Night Blindness

Mobility

Do you travel independently? □ yes □ no
Have you had any Orientation and Mobility training? □ yes □ no
Do you use any travel aids? □ yes □ no

Travel aids used (select all that apply) □ cane □ walker □ guide dog □ wheelchair

Communication Skills

American Sign Language: □ skilled □ conversational □ emerging □ tactile □ none
Signed Exact English: □ skilled □ conversational □ emerging □ tactile □ none
Manual Alphabet (fingerspelling) □ skilled □ emerging □ none
Describe any accommodations needed for you to sign visually. (Distance, avoid glare, lighting, clothing in contrast to skin tone, etc.)

Do you use speech as your primary method of expressive communication? □ yes □ no
Do you read uncontracted braille (I)? □ yes □ no
Do you read contracted braille (II) □ yes □ no
Are you able to read written notes and letters? □ yes □ no
If yes, please provide a sample writing size ____

Emergency Contact

Name: ____

Primary Phone: ________________________________ □ home □ mobile □ text □ VP

Alternate Phone: ________________________________ □ home □ mobile □ text □ VP

Email: ____

Relationship to you: ____

This form was completed by ____.

I certify that the information provided in this application is accurate and true.

Signature: ____ Date: ______________________

Please mail this form to CSC, 1953 S. Beretania Street, Suite 5A, Honolulu, HI 96826 or scan and email a PDF to admin@csc-hawaii.org. The Disability Section of this form must also be received by the CSC before application is considered complete.

Application Section 3 of 3: Disability Verification

The disability verification section is to be completed by a practicing professional who has direct knowledge of the applicant's vision and hearing loss.

Name of Individual who is Deaf-Blind: ____

Name of Attester: ______________________________ Title: ______________________

Agency/Employer: ____

Email: ____ Phone: _______________

Street Address: ____

City/State/Zip: ____

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I certify under penalty of perjury that, to the best of my knowledge, this individual is deaf-blind as defined by the above. My attestation is based on the following:

Attester Signature: ____ Date: _____________

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