**Kentucky Council of the Blind Assistive Technology Grant Program**

**Guidelines**:

*I. Purpose*

The Kentucky Council of the Blind (KCB) created this Assistive Technology Grant Program to help fulfill its mission of enriching the lives of legally blind Kentuckians.  Assistive technology can be very cost prohibitive for many legally blind Kentuckians.  Through its grant program, KCB helps legally blind Kentuckians obtain assistive technology by partially underwriting the cost of such products/services.

*II. Assistive Technology*

For the purpose of this grant program, assistive technology is considered hardware, software, electronic devices, subscription services, equipment, etc. that is standalone or works in conjunction with a computer or other such electronic device that makes it possible for blind people to do things that sighted people can already do without using assistive technology.

*III. Coverage*

The Assistive Technology Grants Program widely covers both hardware and software based assistive technology, upgrades and maintenance agreements, subscription services, ??and (is this “and” needed) computers, and other stand-alone electronic devices. Only new assistive technology, computers, and electronic devices shall be covered, including technology upgrades to newer versions; used or previously owned assistive technology, computers, and electronic devices shall not be covered.

*IV. Guidelines*

A. Grants are awarded to legally blind Kentuckians who are members of the Kentucky Counsel of the Blind, its local chapters, and/or special interest affiliates in good standing for at least the previous nine (9) months.

B. All recipients of KCB Grants are required to ??actually (should “actually” be deleted) demonstrate the purchased item or describe the device or service, including how well it works, its usefulness to a blind person, whether he/she would recommend it to other blind or low-vision people, etc... to a meeting of the KCB membership, the local chapter, or special interest affiliate.

C. Grant recipients shall be required to attend the KCB state convention in the fall ??to receive the award (can “to receive the award” be deleted) unless reasonable circumstances prevent them from doing so.

D. Any purchase made prior to grant application shall not be eligible for a grant.

E. No person shall be eligible to be awarded two (2) grants within a three (3) year period.

F. The ??minimum (should we insert “annual” here) grant award shall be fifty dollars with the total of grants awarded not to accede $500.

G. All awards of grants by the Scholarship Committee are subject to final approval of the Kentucky Council of the Blind Board of Directors.

H. The application deadline is October 1, 2019.

*V. Application*

A. The applicant must submit the following documents to the Scholarship Committee Chair:

1. A completed application.

2. The exact specifications of the assistive technology, service, electronic device, or computer to be purchased.

3. A copy of an official price quote from two vendors or dealers (one quote will suffice if there is no other source for the item).

4. Written verification of legal blindness from an ophthalmologist, rehabilitation counselor, or other reasonable authority (obtained within the past year), including a description of the applicant’s eye condition, visual acuity, and field of vision. This requirement may be waived upon request at the discretion of the Scholarship Committee.

?? B. The Scholarship Committee Chair shall notify the KCB Board of Directors of its awarding of the Assistive Technology Grant including the name of the grant recipient and the item to be purchased and any other relevant information for their approval. (would this not be a recommendation?)

C. Before any grant funds are dispersed by KCB to the seller, the grant recipient must either:

?? 1. Provide the seller with his/her portion of the matching funds and the seller must confirm receipt of such funds to KCB or

?? 2. The grant recipient must provide his/her portion of the matching funds to KCB at which time KCB will disperse funds for the entire amount to the seller. (In 1 and 2, are we matching, fully funding or both?)

D. After the acquisition of the product or service, proof or evidence of the purchase must be presented to the Scholarship Committee Chair or KCB Treasurer for its records.

**KCB Assistive Technology Program Grant Application**

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **PERSONAL DATA (Please Type)** | | | | | | | |
| **Applicant Name:** | |  | | | | | |
| **Address:** | |  | | | | | |
| **City/State/Zip:** | |  | | | | | |
| **Telephone:** | |  | | | | | |
| **E-mail** | |  | | | | | |
| **Attendance of KCB State Convention:** | | | | | | | |
| **Are you able to attend the KCB State Convention from Nov 15-16 2019 in Louisville KY? If the answer is no, why not?** | | | | | | | |
| **":** | | |  | | | | |
| **MEMBERSHIP** | | | | | | | |
| **Please choose: KCB Member at-Large,** | | | | | | | |
| **Local Chapter Member, or Special Interest Affiliate Member** | | | | | |  | |
| **Name of Affiliate, Local Chapter, or Special Interest Affiliate:** |  | | | | | | |
|  | | | | | | | |
| **Have you previously received a KCB Assistive Technology grant?** | | | | | | |  |
| **If yes, please list date of award** | | | | |  | | |
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| **Why are you applying for this grant?** | | | | | | | |
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|  | | | | | | | |
| **Grant Amount Requested?** | | | |  | | | |
| **Describe the assistive technology to be purchased:** | | | | | | | |
|  | | | | | | | |
|  | | | | | | | |
| **Are you capable of paying for any portion of the item? Please list other sources of funds i.e. personal funds, loans, other grants (including from whom):** | | | | | | | |
|  | | | | | | | |
|  | | | | | | | |

**SUPPORTING DOCUMENTS**

1. **The exact specifications of the adaptive technology or computer to be purchased**
2. **A copy of an official price quote from two (2) vendors**
3. **Written verification of legal blindness from an Ophthalmologist or other reasonable authority (obtained within the past year) including a description of the applicant’s eye condition, visual acuity, and field of vision. This may be waved upon request at the discretion of the Scholarship Committee.**

**Statement of Agreement**

***I have read the entire document titled “Kentucky Council of the Blind Assistive Technology Grant Program,” and I understand and agree to all terms and conditions contained therein. All information that I have listed on this application form is accurate to the best of my knowledge and correct to the best of my ability. I understand and agree that any failure on my part to wholly comply with the “Kentucky Council of the Blind Assistive Technology Grant Program” or “Kentucky Council of the Blind Assistive Technology Grant Application Form” may void this application or otherwise render me ineligible for a KCB grant.***

|  |  |  |
| --- | --- | --- |
|  |  |  |
| **Signature of Applicant** |  | **Date Submitted** |

**Send Application and Supporting Documents to:**

**Kentucky Council of the Blind**

**Assistive Technology Grant Program**

**148 Vernon Avenue**

**Louisville, KY 40206**

**Phone: 502-895-4598**

**email: kcb@kentucky-acb.org**

**Visual Verification**

To be completed by an ophthalmologist, optometrist, physician, agency executive serving the blind or other competent authority.

This is to certify that the person named on this scholarship application is known to me and is legally blind in that he/she has a visual acuity of 20/70 or less in the better corrected eye and/or 20 degrees or less visual field in the better corrected eye.

|  |  |
| --- | --- |
| Name: |  |
| Title |  |
| Address: |  |
| City/State/Zip: |  |
| Phone: |  |
| Date: |  |
| Signature: |  |

**RELEASE OF INFORMATION FORM**

***\*To verify blindness, Applicant must complete name, address, and phone number of the physician; sign and date this Release Form and enclose it with the application.***

**I hereby authorize the following named physician, ophthalmologist, organization, agency, or other qualified authority to provide Kentucky Council of the Blind any requested information about my eye condition, visual acuity, and field of vision:**

|  |  |  |
| --- | --- | --- |
| **Name of Organization, Agency, Business, etc.:** | | |
|  | | |
| **Contact Name:** |  | |
| **Title or Position:** |  | |
| **City/State/Zip:** |  | |
| **Physician’s Phone:** |  | |
| **Physician’s Fax:** |  | |
|  | | |
| **Applicant Signature:** | |  |
| **Printed Name:** | |  |
| **Date:** | |  |

**FOR COMMITTEE USE ONLY**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Applicant Name:** | |  | | |
| **Date Received by Committee:** | | | |  |
| **Chairperson:** |  | | | |
| **"Approved" or "Denied":** | | |  | |
| **Date Approved or Denied:** | | |  | |
| **Amount to be paid:** | | | **$** | |
| **If denied, give reason for denial:** | | | | |
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**Signature of Scholarship Technology Chairperson:**