HKNC Helen Keller NATIONAL CENTER for Deaf-Blind Youths and Adults

HKNC Deaf-Blind National Community of Practice (NCOP)

APPLICATION

Agency/Organization Name: _____

_____

Primary contact for this NCOP:_____

Primary contact's mailing address:

_____

Telephone: Voice_____**FAX:**_____

Video Phone: _____

Email: _____

Website: _____

Profile - Overview of your agency/organization's services. Provide a brief summary of the following:

- **Your agency's history of services to individuals who are deaf-blind.**
- **Services currently available to individuals who are deaf-blind?**

1. **What is your agency's definition of deaf-blind? (if available, attach document.)**

2. **Need for services**
   a) **What are your primary professional learning needs when working with individuals who are deaf-blind or who have combined loss of vision and hearing?**

b) How many consumers, who are deaf-blind, are in your state?
   i. Ages 0-22
   ii. Ages 23 – 54
   iii. Ages 55+

3. Presently, who is the primary rehabilitation services provider in your state for individuals who are deaf-blind?

4. If applicable, please describe your agency's involvement with the National DeafBlind Equipment Distribution Program (iCanConnect).

5. What is your involvement with deaf-blind consumer organizations in your state?

6. Does your state have paid or unpaid SSP (support service provider) services? Is your agency/organization involved in these services? Please explain.

7. What expectations, other than those listed above, do you have from HKNC if you become a part of the NCOP?

8. Please include additional comments you would like to share with us about your agency/organization?

Return completed application to:

Cindy Witkow, IRPD
cindy.witkow@hknc.org or mail to
Helen Keller National Center for Deaf-Blind Youths & Adults
C/O Cindy Witkow
141 Middle Neck Road
Sands Point, NY 11050