



New Jersey Department of Human Services  
 Division of the Deaf and Hard of Hearing  
**Equipment Distribution Program**  
**Eligibility Application**



The New Jersey Department of Human Services’ (DHS) Division of the Deaf and Hard of Hearing (DDHH) provides free assistive devices to deaf or hard of hearing individuals through the Equipment Distribution Program (EDP). Since 1993, the DDHH has operated this program to ensure that New Jersey residents with hearing loss have access to critical telecommunications and vital home safety alerting equipment. Upon meeting program eligibility, individuals receive communication devices at no cost. Devices are subject to availability and funding.

Program Eligibility:

- Must have hearing loss
- Must be a New Jersey resident
- Total combined household income must not be greater than 400% of the federal poverty level.

Number of individuals living in household	2026 Federal Poverty Guidelines
1	\$63,840
2	\$86,560
3	\$109,280
4	\$132,000
5	\$154,720
*For each additional person, add \$22,720	Source: <a href="#">U.S. Department of Health and Human Services</a>

1. How many individuals currently live in the household? \_\_\_\_\_

**SECTION 1:** Please provide a copy of one (1) document from List A OR a copy of one (1) document from List B AND a copy of one (1) document from List C.

**List A**

Documents that establish both identity and residency

Select one from the list below

- NJ or Municipal ID card
- NJ Driver's License
- NJ Student ID
- Utility, cell phone, or internet bill
- Bank/insurance statement
- Tax Returns, last two years
- Paystub from employer
- Rent receipt, lease, mortgage
- Letter from social service agency
- Letter from health care provider
- Letter from government agency

**List B**

Documents that establish identity

Select one from the list below

- Student ID card
- Student Transcript
- Passport
- Birth Certificate
- Driver License from another country
- Consulate ID card
- A child's U.S. birth certificate and your name
- Letter from IRS or ITIN
- Marriage Certificate
- Divorce Decree
- U.S. court document

**List C**

Documents that establish residency

Select one from the list below

Signed and dated letter including the full name and phone number of the individual writing the letter from one of the following:

- Landlord
- Representative of worship
- Medical provider
- Service provider
- Shelter acknowledging NJ residency

**SECTION 2:** Please print clearly and in uppercase letters.

**IMPORTANT:** If the equipment is for a minor, please complete the application on behalf of the minor.

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Last Name: \_\_\_\_\_ Pronoun(s):  She/Her  He/Him  They/Them

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Telephone Number: \_\_\_\_\_

Check one:  Cell  Home  Videophone

Email Address: \_\_\_\_\_

**IMPORTANT:** Email addresses will be used to provide UPS tracking updates.

How do you identify:  Deaf  Hard of Hearing  Late-Deafened

Level of Hearing Loss:  Mild  Moderate  Profound

Primary Language:

American Sign Language  English  Spanish  Other: \_\_\_\_\_

Mailing Address:

Street: \_\_\_\_\_ City: \_\_\_\_\_

County: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Physical Address (if different from Mailing Address)

Street: \_\_\_\_\_ City: \_\_\_\_\_

County: \_\_\_\_\_ Zip Code: \_\_\_\_\_

How many individuals live in the household? \_\_\_\_\_

I certify to the best of my knowledge that I meet the program's eligibility requirements and the information in this application is true and correct.

Applicant Signature \_\_\_\_\_ Date: \_\_\_\_\_

**SECTION 3:** If you (or your spouse, if married and living together) receive income from any of the sources listed below, enter the total current yearly income. DO NOT INCLUDE CENTS. If you or your spouse do not receive income from any of the sources listed below, please check the NONE.

**IMPORTANT:** Copies of all relevant, supporting documents must be submitted with the application. Income must be current and dated within the last six (6) months. The date must be clearly visible.

1. Social Security Benefits (Net)	<input type="checkbox"/> YOU: <input type="checkbox"/> SPOUSE:	<input type="checkbox"/> NONE <input type="checkbox"/> NONE	\$ _____ \$ _____
2. Medicare Part B Premium (if deducted from Social Security check)	<input type="checkbox"/> YOU: <input type="checkbox"/> SPOUSE:	<input type="checkbox"/> NONE <input type="checkbox"/> NONE	\$ _____ \$ _____
3. Medicare Part D Premium (if deducted from Social Security check)	<input type="checkbox"/> YOU: <input type="checkbox"/> SPOUSE:	<input type="checkbox"/> NONE <input type="checkbox"/> NONE	\$ _____ \$ _____
4. Interest (including tax-exempt)	<input type="checkbox"/> YOU: <input type="checkbox"/> SPOUSE:	<input type="checkbox"/> NONE <input type="checkbox"/> NONE	\$ _____ \$ _____
5. Dividends	<input type="checkbox"/> YOU: <input type="checkbox"/> SPOUSE:	<input type="checkbox"/> NONE <input type="checkbox"/> NONE	\$ _____ \$ _____
6. IRA Distributions	<input type="checkbox"/> YOU: <input type="checkbox"/> SPOUSE:	<input type="checkbox"/> NONE <input type="checkbox"/> NONE	\$ _____ \$ _____
7. Railroad Retirement	<input type="checkbox"/> YOU: <input type="checkbox"/> SPOUSE:	<input type="checkbox"/> NONE <input type="checkbox"/> NONE	\$ _____ \$ _____
8. Veterans	<input type="checkbox"/> YOU: <input type="checkbox"/> SPOUSE:	<input type="checkbox"/> NONE <input type="checkbox"/> NONE	\$ _____ \$ _____
9. Other pensions	<input type="checkbox"/> YOU: <input type="checkbox"/> SPOUSE:	<input type="checkbox"/> NONE <input type="checkbox"/> NONE	\$ _____ \$ _____
10. Annuities	<input type="checkbox"/> YOU: <input type="checkbox"/> SPOUSE:	<input type="checkbox"/> NONE <input type="checkbox"/> NONE	\$ _____ \$ _____
11. Salary (Gross, before payroll deductions)	<input type="checkbox"/> YOU: <input type="checkbox"/> SPOUSE:	<input type="checkbox"/> NONE <input type="checkbox"/> NONE	\$ _____ \$ _____
12. Other income not listed above (please specify): <input type="checkbox"/> Net Rental <input type="checkbox"/> Worker's Comp <input type="checkbox"/> Alimony <input type="checkbox"/> **Other	<input type="checkbox"/> YOU: <input type="checkbox"/> SPOUSE:	<input type="checkbox"/> NONE <input type="checkbox"/> NONE	\$ _____ \$ _____
** Identify "Other" source of income: _____			

New Jersey Division of the Deaf and Hard of Hearing  
Equipment Distribution Program

## Certification of Disability

**SECTION 4:** This portion of the application must be completed by a treating service provider. Provider, please verify and certify that the applicant will benefit from the use of the requested technology.

This form will be scanned for computerized data capture. Print clearly, in uppercase letters and use blue or black ink only. Correct errors with white correction fluid.

Applicant Name: \_\_\_\_\_

Provider Information:

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Last Name: \_\_\_\_\_

Business Information:

Street: \_\_\_\_\_ City: \_\_\_\_\_

County: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Certification/License Number: \_\_\_\_\_

Expiration Date (MM/DD/YY): \_\_\_\_\_

Provider Profession:

- Doctor/Physician
- Audiologist
- Hearing Aid Specialist Speech
- Pathologist
- Other (please describe): \_\_\_\_\_

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Conditions of Acceptance

**SECTION 5:** Please review the following section in its entirety.

**I understand and agree to the following** (please initial each line to confirm understanding and agreement):

- \_\_\_\_\_ Equipment is the property of the State of New Jersey. I will not sell, pawn, give, or loan the equipment to individuals outside of my household. If I do, I understand I can be criminally prosecuted.
- \_\_\_\_\_ If the equipment request is for a minor, all equipment, obligations, and responsibilities will be transferred at the age of 18.
- \_\_\_\_\_ DHS and DDHH are not liable for any and all claims, damages, and expenses that arise out of the use or misuse of equipment by myself or anyone else.
- \_\_\_\_\_ Signature is required for delivery.
- \_\_\_\_\_ DDHH emails tracking information, I understand I am responsible for delivery tracking.
- \_\_\_\_\_ DDHH is not responsible for packages that may be lost or stolen, I will monitor delivery to ensure receipt.
- \_\_\_\_\_ After three (3) delivery attempts, the shipping service will return the equipment to sender.
- \_\_\_\_\_ If I do not provide changes to information, including but not limited to a change in address, phone number, or email address to DDHH, shipping may be delayed.
- \_\_\_\_\_ DHS and DDHH are not responsible for service plans or bills associated with equipment.
- \_\_\_\_\_ DDHH will **not** replace a device that is damaged due to breakage, it is recommended a protective case be purchased if applicable.
- \_\_\_\_\_ If the equipment is not working, I will **not** try to repair it or take it apart.
- \_\_\_\_\_ If equipment is returned and DDHH determines it has been damaged, a replacement will **not** be allowed.
- \_\_\_\_\_ Equipment will only be replaced if it is within the warranty period.
- \_\_\_\_\_ If the equipment is reported as lost, a replacement will **not** be allowed.
- \_\_\_\_\_ If the equipment is stolen or damaged by someone other than me, a police report must be filed and a copy of the report must be provided to DDHH before a replacement is allowed.
- \_\_\_\_\_ Before an out of state move, I will contact DDHH to arrange the return of equipment.
- \_\_\_\_\_ Arrangement must be made to return equipment if I am unable to do so.
- \_\_\_\_\_ There is a wait of five (5) years before requesting identical equipment. I can reapply for identical equipment after five (5) years.
- \_\_\_\_\_ There is a limit of one (1) identical equipment per application.
- \_\_\_\_\_ There is a limit of one (1) wireless device per application.
- \_\_\_\_\_ If a Smartphone is selected, a cellular service plan is required. All Smartphones offered in this program are “unlocked” so that the individual may choose a service provider of their choice.
- \_\_\_\_\_ I am responsible for the cost for the cellular plan. Applicants in need of low-cost internet service may be eligible through LifeLine: [Home - Universal Service Administrative Company \(lifelinesupport.org\)](http://lifelinesupport.org)
- \_\_\_\_\_ The tablets are Wi-Fi only and do not require a service plan.
- \_\_\_\_\_ DDHH does not provide protective cases for the wireless devices. The devices are subject to breakage, if they are dropped. DDHH will not replace a device that is damaged due to breakage.
- \_\_\_\_\_ It is against the law to file false statements. If I provide false statements in this application or regarding equipment, I understand I can be criminally prosecuted.
- \_\_\_\_\_ If I fail to follow these Conditions of Acceptance, I can be denied the benefit of having equipment offered by the NJ DDHH.

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

New Jersey Division of the Deaf and Hard of Hearing  
Equipment Distribution Program

## **SECTION 6: DEVICES AVAILABLE. SELECT ALL THAT APPLY.**



### **Sonic Alert HA360MK-II**

- Includes HA360M-II HomeAware Main Unit with Integrated Smoke/Co Listener
- Includes HA360SA Doorbell Button
- Includes HA360V-II Bed Shaker
- Scrolling 2-inch alert display
- Strobe, vibration, and audible notifications
- Up to a 105dB audible alarm
- Customizable alerting
- Accessible through available smartphone app
- Works with weather radio and home security system
- One (1) year warranty.



### **Sonic Alert HA360B**

- Optional, add on to the Sonic Alert HA360MK-II
- Connects to the HomeAware Main unit, transmitters, and receivers
- Ultra-high brightness strobe for maximum visibility
- Fully-charged battery lasts for 48 hours
- Charges full within two (2) hours
- One (1) year warranty



### **ADA Entry Alert Notification System**

- Standalone system for phone and home entry alerts, and fully operational alarm clock
- Loud sounds, bright flashing lights, and strong bed vibrations
- Covers up to 260 feet open field
- Up to 5 years battery life
- Two (2) year warranty, accessories 30 days

## SECTION 7: DEVICES AVAILABLE: SELECT ALL THAT APPLY



### Vibio Portable Bluetooth Bed Shaker

- Travel, wireless bed shaker
- Connects directly a cell phone or tablet, via Bluetooth
- Tactile and visual alerts for incoming calls and text messages
- Adjustable vibration power from soft to strong
- Set up to 10 multi alarms
- Two (2) year warranty, accessories 30 days



### ADA Alarm Clock Pro

- Alarm clock with bed shaker
- Ascending loud sounds, with different frequencies
- Bright flashing lights
- Powerful vibrations
- Easily adjustable alarm
- Two (2) year warranty, accessories 30 days



### Kidde Nighthawk 900-0230

- Carbon monoxide alarm
- Digital display
- Continuous digital reading every 15 seconds
- Ten (10) year warranty



### Clarity D714

- Cordless Amplified phone
- Amplifies incoming sound up to 40dB
- Extra-large backlit buttons
- Handset speakerphone
- Belt slip and 2.5 mm handset jack
- Eliminates feedback and distortion
- Hearing aid compatible
- One (1) year warranty

New Jersey Division of the Deaf and Hard of Hearing  
Equipment Distribution Program

## SECTION 8: DEVICES AVAILABLE: SELECT ALL THAT APPLY



### Geemarc AmpliPower60+

- Corded Amplified phone
- Receiver volume control of up to 67dB
- Tone control  $\pm 10$ dB
- Adjustable ringer volume
- Hearing aid compatible
- Extra bright visual ringer indicator (strobe)
- Shaker output
- One (1) year warranty



### ADA Maxi Pro Personal Amplifier

- Bluetooth, digital personal sound amplifier, for conversation and cell phone amplification
- Rechargeable and user friendly
- Includes stereo headphone and internal microphone
- Easy volume adjustments, clear and noise free sound
- Two (2) year warranty, accessories 30 days



### Williams Sound Pocketalker Ultra

- Amplifies sound while reducing background noise
- Lightweight design for portability and ease of use
- Fingertip adjustable volume control
- Five (5) year warranty, accessories 90 days

## SECTION 9: DEVICES AVAILABLE: SELECT ALL THAT APPLY



### ADA Maxi Pro TV Listening System

- Three (3) in one (1) Bluetooth listening system
- Digital, amplification for conversations, cell phone, and TV
- Includes stereo headphones with mic, with semi closed drivers that deliver clear sound
- Two (2) year warranty, accessories 30 days



### Comfort Audio Neckloop

- Lightweight and easy to use neck loop
- Equipped with T-coil
- Amplification and focus for conversations
- Two (2) year warranty, accessories 30 days



### Contacta LA-LOOP PAD

- Inductive hearing loop pad
- Listen wirelessly and directly from source
- Audio streaming from televisions, music systems, and other audio devices
- Integrated clear audio processing
- Two (2) year warranty, accessories 30 days



### SquareGlow Smart Webcam Doorbell

- Versatile device that can function both as a receiver and an accessory
- Detects and provides live video footage
- Can be added to any SquareGlow receivers
- Customizable to suit preferences
- Two (2) year warranty, accessories 30 days

## **SECTION 10: DEVICES AVAILABLE: SELECT ALL THAT APPLY**



### **Minicom IV**

- Teletypewriter (TTY)
- Turbo Code and Auto ID
- Tilted 20-character display
- 43-key, 4 row keyboard
- Printer port to connect an external printer.
- One (1) year warranty



### **VTech DM221**

- Baby monitor
- DECT6.0 digital technology eliminates background noise and prevents interference
- Vibrating sound-alert
- 5- level sound indicator for visual monitoring
- Doubles as a night light
- One (1) year warranty

## SECTION 11: DEVICES AVAILABLE: SELECT ONE ONLY



### **Tablet - Apple iPad**

- 64GB
- Wi-Fi only
- Requires access to internet service
- Includes a three (3) year warranty



### **Tablet - Samsung Galaxy**

- 64GB
- Wi-Fi only
- Requires access to internet service
- Includes a three (3) year warranty



### **Smartphone - Apple iPhone**

- 128GB
- Wi-Fi and 4G
- Requires access to internet service
- Includes a three (3) year warranty



### **Smartphone - Google Pixel**

- 128GB
- Wi-Fi and 4G
- Requires access to internet service
- Includes a three (3) year warranty

**IMPORTANT:** The device will come with the following deaf and hard of hearing accessible apps pre-installed: IP Relay, Video Relay Service, IP Captioned Telephone Service, Video Calls & Video Messaging.

**SECTION 12:** If you are assisting someone with completing this application, please complete the following portion.

**IMPORTANT:** To authorize communication between DDHH and additional parties on the applicant's behalf, the applicant must complete the HIPAA Authorization to Disclose Protected Health Information form (see included).

Please indicate relationship to the applicant by selecting one of the options below:

- Guardian/Family Member
- Friend
- Attorney
- Agency

- Advocate
- Social Worker
- Other (please specify):  
\_\_\_\_\_

Last Name: \_\_\_\_\_ Suffix (Jr., Sr., etc.): \_\_\_\_\_

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Email Address: \_\_\_\_\_

**IMPORTANT:** Email addresses will be used to provide UPS tracking updates.

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Preparer's Signature: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**PLEASE SUBMIT THE APPLICATION BY:**

**MAIL:**

Division of the Deaf and Hard of Hearing  
Equipment Distribution Program  
PO Box 074  
Trenton, NJ 08625-0074

**OR FAX:**

(609) 588-2528

**FOR MORE INFORMATION, CALL:**

(609) 588-2648

(800) 792-8339

(609) 503-4862 videophon3

**EMAIL:**

[DDHH.communications2@dhs.nj.gov](mailto:DDHH.communications2@dhs.nj.gov)

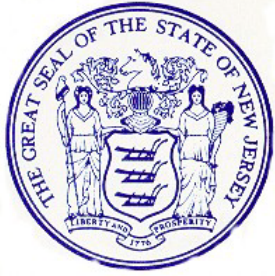
**FOR OFFICE USE ONLY:**

ELIGIBLE       INELIGIBLE, REASON: \_\_\_\_\_

VERIFIED BY: \_\_\_\_\_ DATE: \_\_\_\_\_

VERIFIED BY: \_\_\_\_\_ DATE: \_\_\_\_\_

New Jersey Division of the Deaf and Hard of Hearing  
Equipment Distribution Program



New Jersey Department of Human Services  
Division of the Deaf and Hard of Hearing  
**EQUIPMENT DISTRIBUTION PROGRAM**  
**APPLICATION CHECKLIST**



- A **copy** of ONE (1) document from **List A** to establish residency and identity. **(SECTION 1)**
  - OR** a **copy** of ONE (1) document from **List B** to establish identity AND a **copy** of ONE (1) document to establish residency. **(SECTION 1)**

**IMPORTANT:** Proof of residency must be current and dated within the last six (6) months. The date must be clearly visible.
- Applicant's email address. **(SECTION 2)**

**IMPORTANT:** Email addresses will be used to provide UPS tracking updates.
- Applicant's signature. **(SECTION 2)**
- Income report is complete **(SECTION 3)**

**IMPORTANT:** Proof of income must be current and dated within the last six (6) months. The date must be clearly visible.
- Certification of Disability completed and signed by a treating provider. **(SECTION 4)**
- Conditions of Acceptance reviewed, initialed, and signed. **(SECTION 5)**
- Assistive technology selected. Select all that apply. **(SECTION 6 - 10)**
- Wireless technology selected. Select one only. **(SECTION 11)**
- Preparer's signature, IF applicant received assistance in filling out the application. **(SECTION 12)**
- If the applicant wishes to authorize communication between DDHH and additional parties on the applicant's behalf, applicant must complete a HIPAA Authorization to Disclose Protection Health Information form (see included). **(SECTION 12)**
- Submit application by mail, fax, or email:

DDHH Equipment Distribution Program  
PO Box 074  
Trenton, NJ 08625-0074

Fax: (609) 588-2528  
Email: [DDHH.communications2@dhs.nj.gov](mailto:DDHH.communications2@dhs.nj.gov)



**State of New Jersey**  
**Department of Human Services**  
**Office of Legal and Regulatory Affairs**  
**P.O. BOX 700**  
**Trenton NJ, 08625**

**HIPAA Authorization to Disclose Protected Health Information**

I, \_\_\_\_\_ (Printed name), DOB: \_\_\_\_\_  
understand that my information, which is retained by the New Jersey Department of Human Services (NJHHS) and/or one of its Divisions/Commission, may not be disclosed to a third party without my expressed written authority, unless permitted or required by law. I hereby authorize the NJHHS to disclose my information to:

**Individual's Name or Class of Individuals** \_\_\_\_\_  
\_\_\_\_\_

**Organization/Entity (if applicable):** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Telephone Number:** \_\_\_\_\_ **Fax Number:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_

**Specify the Division(s) you are seeking information from:**

- Commission for the Blind and Visually Impaired
- Division of Aging Services
- Division of Developmental Disabilities
  - Green Brook Developmental Center
  - New Lisbon Developmental Center
  - Woodbine Developmental Center
  - Hunterdon Developmental Center
  - Vineland Developmental Center
- Division of Deaf and Hard of Hearing
- Division of Disability Services
- Division of Family Development
- Division of Medical Assistance and Health Services
- Division of Mental Health and Addiction Services

**Identify the information to be disclosed.** (Check all that apply):

Entire medical<sup>1</sup> record

---

---

---

Partial medical record - Specify date range and/or the subset of the records being requested.

Other information (level of detail to be released). Specify:

---

---

---

Psychotherapy Records

Substance Use Disorder (SUD) Records

If the request includes disclosure of SUD information/records, explicitly identify the SUD information that may be disclosed. Use additional pages if necessary.

---

---

---

HIV/AIDS Related Information

If the request includes disclosure of HIV/AIDS related, explicitly identify the HIV/AIDS related information that may be disclosed. Use additional pages if necessary.

---

---

---

**Form of Disclosure:**

Electronic copy

Hard copy

Purpose of this disclosure (ex. Legal/litigation; School; etc.):

Specify: \_\_\_\_\_

---

---

**Duration of Disclosure:** This authorization shall be in force and effect until:

\_\_\_\_\_ (Date or Event of Expiration) at which time this Authorization expires. I understand that upon this expiration date, NJDHS will no longer provide my information to the person or persons stated above, and that if I wish for this person or persons to continue to receive information, I must execute another authorization.

---

<sup>1</sup> Medical records mean “designated record set” as defined by 45 CFR 164.501. Medical records do not include psychotherapy notes.

**I understand that:**

- I have the right to revoke (take back) this Authorization, in writing, at any time, except to the extent the NJDHS has taken action in reliance on this authorization, by sending written notice to the Department of Human Services, Attention: HIPAA Privacy Officer, PO Box 700, Trenton, NJ 08625. The exceptions to revocation are fully detailed in the DHS Notice of Privacy Practices. The effective date of the revocation is the date on which the revocation was received by a Department employee. If information has already been disclosed in reliance on this authorization, revoking it will only prevent future disclosure.
- Information used or disclosed pursuant to this Authorization may be subject to re- disclosure by the recipient and may no longer be protected by the Department of Human Services, Federal law, or State law.
- SUD information/records cannot be further disclosed by the person or entity named above without the further authorization because 42 CFR part 2 prohibits unauthorized disclosure of these records. (42 CFR 2.32)
- HIV/AIDS related information cannot be further disclosed by the person or entity named above without written consent/authorization of the individual in accordance with N.J.S.A. 26:5C-11. See also N.J.S.A. 26:5C-8.
- NJDHS and its agencies will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this Authorization.

**By signing below, I fully acknowledge and agree to the above terms.**

\_\_\_\_\_  
Signature of Individual or  
Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name

\_\_\_\_\_  
Authority of Personal Representative (Provide a copy of the Letters of Guardianship, Power of Attorney, Birth Certificate, Order of Custody, etc.)

**If you wish to file a complaint with our agency or get more information on how you can file a complaint with the Department of Human Services, please contact the Privacy Officer in the Office of Legal & Regulatory Affairs, P.O. Box 700 Trenton, NJ 08625, or the Office of Civil Rights, US Department of Health & Human Services, 26 Federal Plaza- Suite 3312, New York, NY 10278.**