

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: U.S. Department of Health and Human Services

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	List B	List C
Documents that establish both identity and residency	Documents that establish identity	Documents that establish residency
Select one from the list below	Select one from the list below	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	• 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	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: _____

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

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 contact DDHH. 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://Home-UniversalServiceAdministrativeCompany.org)

_____ The tablets are Wi-Fi only and do not require a service plan.

_____ 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 thirty (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 thirty (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 thirty (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

SECTION 8: DEVICES AVAILABLE: SELECT ALL THAT APPLY

☐

Geemarc Ampli550

- Corded amplified phone
- Up to 55dB receive amplification
- Adjustable volume and tone control
- Amplified speakerphone up to +15dB
- 95dB ringer with visual indicator
- Hearing aid compatible
- 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 thirty (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 ninety (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 thirty (30) days

☐

Neck Loop

- Lightweight and comfortable
- Equipped with T-coil
- Compatible with personal amplifiers and other devices
- High-output dual-channel audio
- Safety breakaway neck strap
- Two (2) year warranty, accessories thirty (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 thirty (30) days

SECTION 10: DEVICES AVAILABLE: SELECT ALL THAT APPLY

☐

SquareGlow Smart WiFi Home Kit

- Home notification system, Includes doorbell transmitter, phone signaler, and WiFi flashers
- Receive visual alerts in up to two (2) rooms
- Seven (7) customizable lights colors
- Fifty-two (52) customizable ringtones
- Adjustable volume up to 120dB
- Two (2) year warranty, accessories 30 days

☐

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

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)**

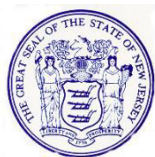
IMPORTANT: Proof of residency must be current and dated within the last six (6) months. The date must be clearly visible.
- ☐ Applicant's email address. **(SECTION 2)**

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



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 (NJ DHS) 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 NJ DHS 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 medical¹ 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.

¹ 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.