New Jersey Department of Human Services
Division of the Deaf and Hard of Hearing

# NEW JERSEY HEARING AID PROJECT
## Eligibility Application, Form A

## Important Note:

**This application form to be used only by applicants who are menmbers of the Pharmaceutical Assistance for the Aged and DIsabled ( PAAD)**

**2020 Income Limits: Single: less than $28,399;Married: less than $34,817**

### SECTION 1 & 2: TO BE COMPLETED BY APPLICANT

**1.** Enter your PAAD number, name, date of birth and sex. List your Social Security number. Use CAPITAL LETTERS. Print only one letter or number in each box. List date of birth verified by Social Security.

PAAD Number

*Last Name*

***Suffix (Jr., Sr., etc.)***

First Name

Middle Initial

**Sex Male/Female**

Month / Day / Year

Social Security Number - -

Date of Birth / /

**2.** Enter your Home Address.

Address

City

State

Zip Code -

**see other side**

## SECTION 3: TO BE COMPLETED BY PHYSICIAN OR LICENSED AUDIOLOGIST

I have examined this applicant and determined the necessity of a hearing aid.

_____ Telephone (_____) _____

Name of Physician or Licensed Audiologist (Print)

_____

Address of Physician or Licensed Audiologist

_____ Date _____

Signature of Physician or Licensed Audiologist

## APPLICANTS CERTIFICATION AND WAIVER

I certify that the information above is true and accurate to the best of my knowledge. I understand that if it is determined that benefit has been improperly issued to me, I will be required to repay such benefit. I understand to verify my eligibility for NJHAP it may be necessary to obtain certain information from the records of the Pharmaceutical Assistance to the Aged and Disabled (PAAD) Program, and I authorize release of that information. I hereby assign to the State of New Jersey any right to hearing aid coverage to which I may be entitled under any other plan of assistance or insurance from any other liable third party.

I certify that I do not currently own a hearing aid appropriate for my hearing loss.

_____ _____

Signature of Applicant Date

**DO NOT WRITE BELOW THIS LINE**

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For Office Use only

Yes.. ☐ Verified by _____ Date _____

No.. ☐

**Return form to:**
**DDHH**
**New Jersey Hearing Aid Project**
**PO Box 074, Trenton, NJ 08625-0074**
**Or (609) 588-2528 Fax**
**For more information call 609-588-2648; 800-792-8339; 609-503-4862 VP**

**Revised 12/04/20**