New Jersey Department of Human Services
Division of the Deaf and Hard of Hearing
NEW JERSEY HEARING AID PROJECT
ELIGIBILITY APPLICATION, FORM A

IMPORTANT: This application form is to be used only by applicants who *are* members of the Pharmaceutical Assistance for the Aged and Disabled (PAAD)

The New Jersey Hearing Aid Project offers free refurbished hearing aids for individuals that meet program eligibility. The Hearing Aid Project is an innovative initiative launched by the New Jersey Division of the Deaf and Hard of Hearing (DDHH), in partnership with Montclair State University.

Program Eligibility:

- Must have hearing loss
- Must be above the age of 65 OR are disabled and receiving Social Security Disability Insurance (SSDI)
- Must be a New Jersey resident

2026 INCOME GUIDELINES:
Single: no greater than $54,943
Married: no greater than $62,390

SECTION 1: TO BE COMPLETED BY THE APPLICANT

This form will be scanned for computerized data capture. Please follow the instructions to ensure that the application is processed quickly and accurately.

- Use blue or black ink only.
- Print clearly, in uppercase letters.
- Correct errors with white correction fluid

PAAD Number: _____

First Name: _____ Middle Initial: _____

Last Name: _____ Suffix (Jr., Sr., etc.) _____

Pronoun(s): ☐She/Her ☐ He/Him ☐ They/Them

Date of Birth: _____/_____/_____

Social Security Number: _____ - _____- _____

Telephone Number: (_____) _____ - _____

Email Address: _____

Preferred Method of Communication: ☐Telephone ☐Email

Street Address: _____

City: _____ State: _____ Zip Code: _____

<u>SECTION 2</u>: TO BE COMPLETED BY THE TREATING PHYSICIAN OR LICENSED AUDIOLOGIST.

This form will be scanned for computerized data capture. Please follow the instructions to ensure that the application is processed quickly and accurately.

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- Correct errors with white correction fluid

I HAVE EXAMINED THIS APPLICANT AND HAVE DETERMINED THE NECESSITY OF A HEARING AID.

_____ License Number: _____
Physician or Licensed Audiologist (Print Name)

_____ Date: _____
Signature of Physician or Licensed Audiologist

_____
Business Address of Physician or Licensed Audiologist

Telephone Number: (_____) _____ - _____

<u>SECTION 3</u>: TO BE COMPLETED BY APPLICANT

APPLICANTS CERTIFICATION AND WAIVER

I certify to the best of my knowledge that the information above is true and accurate to the best of my knowledge. I certify that I do not currently own a hearing aid(s) appropriate for my hearing loss and I meet the Program's eligibility requirements.

I understand to verify my eligibility for NJHAP it may be necessary for DDHH to obtain certain information. I authorize the release of information necessary to determine my eligibility from the records in possession of the Social Security Administration (SSA), the Internal Revenue Service (IRS), New Jersey Division of Taxation, New Jersey Division of Medical Assistance and Health Services, employers, banks, utility companies, and others as the need arises. It is understood that I may be liable for repayment for any benefits or payments which are determined to have been incorrectly provided. I am authorizing the New Jersey Hearing Aid Project (NJHAP) to disclose to other state agencies the financial information listed, as well as utility information, and other identifiable information from my file, such as my name, date of birth, and social security number to start the application process for Medicare Savings Programs, USF/LIHEAP, Supplemental Nutrition Assistance Program (SNAP) and Pharmaceutical Assistance to the Aged and Disabled (PAAD).

If you are unable to sign, a representative may sign for you.

_____ Date: _____

Signature of Applicant

<u>SECTION 4</u>: If you are assisting someone in completing this application, please complete the following portion.

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

☐ Family Member
☐ Friend
☐ Attorney
☐ Agency
☐ Advocate
☐ Social Worker
☐ Other (please specify):
_____

First Name: _____ Middle Initial: _____

Last Name: _____ Suffix (Jr., Sr., etc.) _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: (_____) _____ - _____

Email Address: _____

Preferred Method of Communication: ☐Phone ☐Email

Preparer's Signature: _____

SECTION 5: FOR OFFICIAL USE ONLY
DO NOT WRITE BELOW THIS LINE.

FOR OFFICE USE ONLY:

☐ ELIGIBLE ☐ INELIGIBLE, REASON: _____

VERIFIED BY: _____ DATE: _____

VERIFIED BY: _____ DATE: _____

APPLICATIONS MAY BE SUBMITTED BY:

MAIL:
Division of the Deaf and Hard of Hearing
New Jersey Hearing Aid Project
PO Box 074
Trenton, NJ 08625-0074

EMAIL:
DDHH.communications2@dhs.nj.gov

OR FAX:
(609) 588-2528

FOR MORE INFORMATION, CONTACT DDHH:
(609) 588-2648
(800) 792-8339 toll free
(609) 503-4862 videophone