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

IMPORTANT: This application form is to be used only by applicants who are NOT 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

Please answer the following questions by checking the appropriate box. Please select one box.

1. Do you have a hearing loss?
   ☐ YES ☐ NO

If you answered "NO" to question 1, please do *not* complete this application. Individuals who do not have hearing loss are *not* eligible for NJHAP.

2. Do you currently own a functioning hearing aid(s) appropriate for your hearing loss?
   ☐ YES ☐ NO

If you answered "YES" to question 2, please do *not* complete this application. Individuals with functioning hearing aids are *not* eligible for NJHAP.

3. Are you 65 years of age or older?
   ☐ YES ☐ NO

4. Are you disabled and receiving Social Security Disability Insurance (SSDI)?
   ☐ YES ☐ NO

If you answered "NO" to questions 3 **and** 4, please do *not* complete this application. Individuals who are *not* 65 years or older, **or** are *not* disabled and receiving SSDI are *not* eligible for NJHAP.

5. Are you a Medicaid recipient?
   ☐ YES ☐ NO

If you answered, "YES" to question 5, please do *not* complete this application. Individuals with Medicaid are *not* eligible for NJHAP.

6. Are you a PAAD (Pharmaceutical Assistance for the Aged and Disabled) recipient?
   ☐ YES ☐ NO
7. If you answered "YES" to question 6, please enter your PAAD number:

   _____

SECTION 2: THE FOLLOWING DOCUMENTATION MUST ACCOMPANY THIS APPLICATION.

Please provide a **copy** of ONE (1) document from List A **OR** a **copy** TWO (2) documents from List B to establish proof of age.

IMPORTANT: Proof of age must be current, if applicable and Date of Birth must be included.

List A

☐ Birth certificate
☐ Baptismal certificate
☐ Social security records
☐ Railroad retirement records

List B

☐ Driver's license
☐ Delayed birth certificate
☐ State of Federal Census records
☐ School records
☐ Foreign Passport
☐ Voting records
☐ Marriage certificate

SECTION 3: THE FOLLOWING DOCUMENTATION MUST ACCOMPANY THIS APPLICATION.

Please provide a **copy** of TWO (2) of the following documents to establish proof of residency.

IMPORTANT: Proof of residency must be current and dated within the last six (6) months, date must be clearly visible:

☐ NJ or Municipal ID card
☐ NJ Driver's license
☐ NJ Student ID

☐ Public utility records and receipts (e.g. Electric, telephone bill, etc.)
☐ Bank statements
☐ Mortgage statements
☐ Lease agreement
☐ Tax Returns, last two years

☐ Social Security records (e. g. Third Party Query, Form SSA-2458, etc.)
☐ Post Office records
☐ Bills of business or professionals (e.g. Doctors, pharmacies, etc.

IMPORTANT: Please **do not** submit original documentation. Original documents will not be returned.

IMPORTANT: Processing may be delayed if not all necessary documents are sent with this application. In certain cases, additional documentation may be required.

APPLICATION FORM:

SECTION 4: 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.

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

Marital Status (Please check ONE box.):

☐ Single
☐ Married
☐ Widowed
☐ Separated *
☐ Divorced

Has there been a change to your marital status within the last year? (Please check ONE box.)

☐ YES ☐ NO

If you answered YES, please list the date of change: _____/_____/_____

IMPORTANT: * If you answered "Separated", please submit an "Affidavit of Separation" form, which MUST accompany this application. If an "Affidavit of Separation" is needed, call (800) 792-9745.

SECTION 5: If you answered "Married" please complete the following section regarding your spouse. Please follow the instructions listed in "**SECTION 4**". All questions MUST be answered if married and living together.

First Name: _____ Middle Initial: _____

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

Date of Birth: _____/_____/_____

Social Security Number: _____ - _____- _____

SECTION 6: Please complete the following section regarding your physical address. Please follow the instructions listed in "**SECTION 3**".

Street Address: _____

City: _____ State: _____ Zip Code: _____

1. Is this your primary place of residence? (Please check one box.)

   ☐ YES ☐ NO

IMPORTANT: A seasonal or temporary residence in New Jersey **does not** qualify as a primary place of residence for the NJHAP.

2. Please enter your Mailing Address, if different from above.

Street Address: _____

City: _____ State: _____ Zip Code: _____

SECTION 7: Please answer the following questions by checking one box.

1. Did you and/or your spouse file a Federal or State income tax return last year?

☐ YES

☐ NO

If you answered "YES", signed **copies** of each return, including all schedules, must accompany this application.

SECTION 8: If you (or your spouse, if married and living together) receive income from any of the sources listed below, please enter the total current yearly income in the appropriate boxes. DO NOT INCLUDE CENTS. If you or your spouse do not receive income from any of the sources listed below, please check the NONE box.

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 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: _____			

<u>SECTION 9</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

_____ Date: _____
Signature of Spouse, if applicable

SECTION 10: If you are assisting someone in completing this application, please complete the following portion.

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

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 11: TO BE COMPLETED BY THE TREATING PHYSICIAN OR AUDIOLOGIST.

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: (_____) _____ - _____

SECTION 12: FOR OFFICE USE ONLY
DO NOT WRITE BELOW THIS LINE.

FOR OFFICE USE ONLY:

☐ ELIGIBLE ☐ INELIGIBLE, REASON: _____

VERIFIED BY: _____ DATE: _____

VERIFIED BY: _____ DATE: _____

PLEASE SUBMIT THE FORM 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:
(609) 588-2648
(800) 792-8339
(609) 503-4862 videophone

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

NEW JERSEY HEARING AID PROJECT APPLICATION CHECKLIST

☐ A **copy** of ONE (1) document from **List A** to establish proof of age. **(SECTION 2)**

☐ OR **copies** of TWO (2) documents from **List B** to establish proof of age.

☐ **Copies** of TWO (2) documents to establish proof of residency. **(SECTION 3)**

IMPORTANT: Proof of residency must be current and dated within the last six (6) months. The date must be clearly visible.

☐ A **copy** of the "Affidavit of Separation", IF separated. **(SECTION 4)**

☐ A **signed copy** of last year's Federal or State income tax including all schedules, if you answered YES. **(SECTION 7)**

IMPORTANT: Please do not submit original documentation. Original documents will not be returned**.**

IMPORTANT: Processing may be delayed if not all necessary documents are sent with this application. In certain cases, additional documentation may be required.

☐ Income report is complete **(SECTION 8)**

IMPORTANT: Proof of income must be current and dated within the last six (6) months. The date must be clearly visible.

☐ Applicant Certification and Waiver is signed by Applicant **(SECTION 9)**

☐ Applicant Certification and Waiver is signed by Spouse, IF married **(SECTION 9)**

☐ Preparer's signature, IF applicant received assistance in filling out the application. **(SECTION 10)**

☐ Release of Information is included, IF applicant received assistance in filling out the application. **(SECTION 10)**

☐ Signature of a treating physician or licensed audiologist **(SECTION 11)**