New Jersey Department of Human Services
Division of the Deaf and Hard of Hearing
HEARING AID ASSISTANCE
TO THE AGED AND DISABLED

The Hearing Aid Assistance to the Aged and Disabled (HAAAD) offers reimbursement to offset the cost of hearing aids. Reimbursement of up to $1,000 – $500 per hearing aid, is available to eligible applicants.

Program Eligibility:

- Must have hearing loss
- Must be above the age of 65 OR are disabled and receiving Social Security Disability benefits
- 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

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: _____

I am requesting reimbursement for the following hearing aid(s):

☐ Left ☐ Right ☐ Both

SECTION 2: THE FOLLOWING DOCUMENTATION MUST ACCOMPANY THIS APPLICATION.

☐ A receipt for the purchase of the hearing aid.

IMPORTANT: The receipt must be dated on or after approval for the Pharmaceutical Assistance for the Aged and Disabled (PAAD) in order for reimbursement.

☐ A written statement from a treating physician attesting to the medical necessity for obtaining a hearing aid. Applicant may obtain the physician's signature below OR attach a copy of the prescription for the hearing aid.

IMPORTANT: Applicant must sign the HAAAD eligibility application.

SECTION 3: APPLICANT 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 the 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.

_____ Date: _____
Signature of Applicant

SECTION 4: 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.) _____

City: _____ State: _____ Zip Code: _____

Telephone Number: (_____) _____ - _____

Email Address: _____

Preferred Method of Communication: ☐Phone ☐Email

Preparer's Signature: _____

<u>SECTION 4</u>: TO BE COMPLETED BY THE TREATING PHYSICIAN.

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

_____ License Number: _____
Physician (Print Name)

_____ Date: _____
Signature of Physician

_____
Business Address of Physician

Telephone Number: (_____) _____ - _____

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

FOR OFFICE USE ONLY:

☐ ELIGIBLE ☐ INELIGIBLE, REASON: _____

VERIFIED BY: _____ DATE: _____

APPLICATIONS MAY BE SUBMITTED BY:

MAIL:
Hearing Aid Assistance to the Aged and Disabled
PO Box 715
Trenton, NJ 08625-0715

OR FAX:
(609) 588-7171

FOR MORE INFORMATION, CONTACT: 1 (800) 792-9745

OR WRITE:

Hearing Aid Assistance to the Aged and Disabled
PO Box 715
Trenton, NJ 08625-0715

WHAT IS HEARING AID ASSISTANCE TO THE AGED AND DISABLED?

This is a State of New Jersey program which provides up to $500 reimbursement to eligible residents who purchase a hearing aid, but does not provide for the cost of batteries, repairs, or similar services.

HOW DO I APPLY?

If you are currently enrolled in the Pharmaceutical Assistance to the Aged and Disabled Program (PAAD), you must complete a HAAAD application and submit the following documentation:

1. A paid in full receipt for the purchase of your hearing aid. The cost of the hearing aid(s) must be equal to or greater than the reimbursement amount.
2. A written statement from your physician attesting to the medical necessity for obtaining a hearing aid.
3. You must sign the HAAAD eligibility application.

If you are **not** currently enrolled in the PAAD program, you must complete a PAAD application as well. This is needed to verify your age or disability status, state residency, and annual income. Receipt must be dated on or after being approved for PAAD in order for reimbursement.

Applications may be obtained by calling the toll-free number:

1-800-792-9745

HOW IS THE TERM "HEARING AID" DEFINED FOR THE PURPOSE OF THIS PROGRAM?

"Hearing aid" means a custom-fitted ear-level or body-worn electronic device to enhance communication for the hearing impaired.

HOW SOON WILL I GET MY $500 PAYMENT AFTER I APPLY?

Once your application has been approved, you should receive your payment in approximately six to eight weeks.

WOULD I BE ELIGIBLE IF I HAVE OTHER HEARING AID COVERAGE?

If you are a Medicaid recipient or have other health insurance coverage or retirement benefits that provide full hearing aid coverage, you would not be eligible. If you have only limited or partial coverage, you would be eligible for a supplementary payment.

HOW DO I KNOW IF I AM ELIGIBLE?

- A New Jersey resident.
- NJ resident must be at least 65 years of age, or receiving Social Security Disability benefits.