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

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

1. Have you purchased hearing aids?
   ☐ YES ☐ NO

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

2. Have you received hearing aids through the Division of the Deaf and Hard of Hearing's (DDHH) New Jersey Hearing Aid Project (NJHAP) within the last calendar year?
   ☐ YES ☐ NO

If you answered "YES" to question 2, please do *not* complete this application. Individuals who received hearing aids through DDHH's NJHAP within the last calendar year are *not* eligible for HAAAD.

SECTION 2: 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 3: 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 4: 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 5: If you are assisting someone in 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:

☐ 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: _____

SECTION 6: 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 7: 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

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 (NJDHS) 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 NJDHS 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 medical[1] 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.