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

2024 INCOME GUIDELINES:
Single: no greater than $52,142
Married: no greater than $59,209

SECTION 1: Please answer the following questions by checking the appropriate boxes, to determine eligibility.

1. Do you have a hearing loss?

☐ YES
☐ NO

If you answered NO to question 1, please do not complete this application, as you are not eligible to participate in this program.

2. Do you currently own a functioning hearing aid(s) appropriate for your hearing loss? (Please check one box.)

☐ YES
☐ NO

If you answered YES to question 2, please do not complete this application, as you are not eligible to participate in this program.

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, as you are not eligible to participate in this program.

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

List A

☐ Birth certificate
☐ Baptismal certificate
☐ Social security records that include date of birth
☐ Railroad retirement records that include date of birth

List B

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

SECTION 3: Please provide a copy of TWO (2) of the following documents to establish proof of residency:

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

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

IMPORTANT: Processing will be delayed if all necessary documents are not sent with this form. 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.

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

First Name: _____ Middle Initial: ____

Date of Birth: _____ / _____ / _____

Social Security Number: _____ - _____ - _____

Marital Status (Please check ONE box.):

☐ Single ☐ Separated *
☐ Married ☐ Divorced
☐ Widowed

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: _____ / _____ / _____

***If you answered "Separated", please call (800) 792-9745 to request an "Affidavit of Separation" form, which MUST accompany this application.**

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.

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

First Name: _____ Middle Initial: ____

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**".

Stress Address: _____

City: _____ State: _____

Zip Code: _____

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

☐ YES
☐ NO

IMPORTANT: A seasonal of temporary residence in New Jersey DOES NOT qualify as a principal place of residence for the New Jersey Hearing Aid Project.

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

Stress 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, please submit signed copies of each return, including all schedules, with 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.

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: _____			

SECTION 9: Please complete the following Applicant Certification and Waiver.

I certify to the best of my knowledge that I meet the Program's eligibility requirements and will notify the Program immediately if my income rises above the eligible limit, I moved from New Jersey, or become Medicaid eligible. 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.

Applicant signature: _____

Phone Number: _____ Date: _____

Spouse's signature: _____ Date: _____

SECTION 10: If you are assisting someone else in completing this application, please complete the following portion and include a Release of Information Form.

1. Please check one of the following boxes regarding relationship to the applicant.

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

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

First Name: _____ Middle Initial: ____

Stress Address: _____

City: _____ State: _____ Zip Code: _____

Preparer's Signature: _____ Phone Number: _____

SECTION 11: The following portion of this application is to be completed by the treating Physician or Licensed Audiologist. Please use CAPITAL LETTERS.

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: (_____) _____

PLEASE SUBMIT THE FORM BY:

MAIL:
Division of the Deaf and Hard of Hearing
New Jersey Hearing Aid Project
PO Box 715
Trenton, NJ 08625-0715

EMAIL:
DDHH.communications2@dhs.nj.gov

OR FAX:
(609) 588-2528

FOR MORE INFORMATION, CALL:
(609) 588-2648
(800) 792-8339
(609) 503-4862 videophone

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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 age. **(SECTION 3)**

☐ 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)**

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

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

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

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

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

☐ Treating Physician's signature **(SECTION 11)**