



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 (NJHAP) 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

Division of the Deaf and Hard of Hearing
New Jersey Hearing Aid Project

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. Have you received hearing aid reimbursement through DDHH’s Hearing Aid Assistance for the Aged and Disabled (HAAAD) within the last calendar year?
 YES NO

If you answered “YES” to question 6, please do *not* complete this application. Individuals who received hearing aid reimbursement through DDHH’s HAAAD within the last calendar year are *not* eligible for NJHAP.

7. Are you a PAAD (Pharmaceutical Assistance for the Aged and Disabled) recipient?
 YES NO

If you answered “YES” to question 7, please do *not* complete this application. PAAD recipients must complete [NJHAP application Form A](#).

SECTION 2: A COPY OF 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: A COPY OF 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:

- | | |
|--|---|
| <input type="checkbox"/> NJ or Municipal ID card | <input type="checkbox"/> Lease agreement |
| <input type="checkbox"/> NJ Driver's license | <input type="checkbox"/> Tax Returns, last two years |
| <input type="checkbox"/> NJ Student ID | <input type="checkbox"/> Social Security records (e. g. Third Party Query, Form SSA-2458, etc.) |
| <input type="checkbox"/> Public utility records and receipts (e.g. Electric, telephone bill, etc.) | <input type="checkbox"/> Post Office records |
| <input type="checkbox"/> Bank statements | <input type="checkbox"/> Bills of business or professionals (e.g. Doctors, pharmacies, etc.) |
| <input type="checkbox"/> Mortgage statements | |

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: TO BE COMPLETED BY THE APPLICANT

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: _____

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: TO BE COMPLETED BY THE APPLICANT.

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: TO BE COMPLETED BY THE APPLICANT.

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 clearly visible.

1. Social Security Benefits (Net)	<input type="checkbox"/> YOU <input type="checkbox"/> SPOUSE	<input type="checkbox"/> NONE <input type="checkbox"/> NONE	\$ _____ \$ _____
2. Medicare Part B Premium (If deducted from Social Security check)	<input type="checkbox"/> YOU <input type="checkbox"/> SPOUSE	<input type="checkbox"/> NONE <input type="checkbox"/> NONE	\$ _____ \$ _____
3. Medicare Part D Premium (If deducted from Social Security check)	<input type="checkbox"/> YOU <input type="checkbox"/> SPOUSE	<input type="checkbox"/> NONE <input type="checkbox"/> NONE	\$ _____ \$ _____
4. Interest (Including tax-exempt)	<input type="checkbox"/> YOU <input type="checkbox"/> SPOUSE	<input type="checkbox"/> NONE <input type="checkbox"/> NONE	\$ _____ \$ _____
5. Dividends	<input type="checkbox"/> YOU	<input type="checkbox"/> NONE	\$ _____

	<input type="checkbox"/> SPOUSE	<input type="checkbox"/> NONE	\$ _____
6. IRA Distributions	<input type="checkbox"/> YOU <input type="checkbox"/> SPOUSE	<input type="checkbox"/> NONE <input type="checkbox"/> NONE	\$ _____ \$ _____
7. Railroad Retirement	<input type="checkbox"/> YOU <input type="checkbox"/> SPOUSE	<input type="checkbox"/> NONE <input type="checkbox"/> NONE	\$ _____ \$ _____
8. Veterans	<input type="checkbox"/> YOU <input type="checkbox"/> SPOUSE	<input type="checkbox"/> NONE <input type="checkbox"/> NONE	\$ _____ \$ _____
9. Other pensions	<input type="checkbox"/> YOU <input type="checkbox"/> SPOUSE	<input type="checkbox"/> NONE <input type="checkbox"/> NONE	\$ _____ \$ _____
10. Annuities	<input type="checkbox"/> YOU <input type="checkbox"/> SPOUSE	<input type="checkbox"/> NONE <input type="checkbox"/> NONE	\$ _____ \$ _____
11. Salary (Gross, before payroll deductions)	<input type="checkbox"/> YOU <input type="checkbox"/> SPOUSE	<input type="checkbox"/> NONE <input type="checkbox"/> NONE	\$ _____ \$ _____
12. Other income not listed above: (Please specify.)	<input type="checkbox"/> YOU <input type="checkbox"/> SPOUSE	<input type="checkbox"/> NONE <input type="checkbox"/> NONE	\$ _____ \$ _____
<input type="checkbox"/> Net Rental <input type="checkbox"/> Worker's Comp <input type="checkbox"/> Alimony <input type="checkbox"/> **Other			
** Identify "Other" source of income: _____			

SECTION 9: 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.

Signature of Applicant

Date: _____

Signature of Spouse, if applicable

Date: _____

SECTION 10: IF APPLICABLE, TO BE COMPLETED BY THE INDIVIDUAL ASSISTING THE APPLICANT.

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.) _____

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.

Physician or Licensed Audiologist (Print Name)

License Number: _____

Signature of Physician or Licensed Audiologist

Date: _____

Business Address of Physician or Licensed Audiologist

Telephone Number: (_____) _____ - _____

SECTION 12: FOR OFFICIAL 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

OR FAX:

(609) 588-2528

FOR MORE INFORMATION, CONTACT:

(609) 588-2648

(800) 792-8339

(609) 503-4862 videophone

EMAIL:

DDHH.communications2@dhs.nj.gov



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 applicable. **(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)**

- If the applicant wishes to authorize communication between DDHH and additional parties on the applicant's behalf, applicant must complete a HIPAA Authorization to Disclose Protection Health Information form (see included). **(SECTION 10)**

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



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 (NJ DHS) 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 NJ DHS 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 medical¹ 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.