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

NEW JERSEY HEARING AID PROJECT
Eligibility Application, Form B

IMPORTANT NOTE:
Specific hearing aids prescribed for an individual may not be available at all times.
Availability is dependent upon donations of used hearing aids and funding for reconditioning.

2013 Income Limits: Single: less than $25,734; Married: less than $31,563

This form will be scanned for computerized data capture. Please follow these instructions to ensure that your application is processed quickly and accurately.

- Use blue or black ink. Do not use red ink or pencil.
- Print clearly in uppercase block letters (see examples below).
- Print only one number or letter in each box.
- Stay inside boxes.
- Correct errors with white correction fluid.

A	B	C	D	E	F	G	H	I	J	K	L	M
N	O	P	Q	R	S	T	U	V	W	X	Y	Z
1	2	3	4	5	6	7	8	9	0			

This form must be completed and returned to:

NJ DHS, Hearing Aid Project
PO Box 715, Trenton, NJ 08625-0715

You must submit proof with this form.
Processing will be delayed if all necessary documents are not sent with this form.

DO NOT SEND ORIGINAL SUPPORTING DOCUMENTS. SEND COPIES. ORIGINALS WILL NOT BE RETURNED.

If you are applying for New Jersey Hearing Aid Project (NJHAP), supply the following documents:

- Proof of age (must show date of birth)
- Proof of principal place of residence, dated within the last 6 months
- Last year's income tax return, if filed
- Physician/Licensed Audiologist statement/signature attesting to the necessity of a hearing aid.

New Jersey Hearing Aid Project requires individuals be age 65 or older.

If you are 65 years of age or older, supply proof of age that shows your date of birth.

Submit a COPY of one of the following to document DATE OF BIRTH:

- Birth certificate
- Baptismal Certificate
- Social Security record that indicates your date of birth
- Railroad Retirement record that indicates your date of birth

If you cannot supply the above document(s), copies of any TWO of the following that indicate DATE OF BIRTH will be acceptable.

- Driver's License
- Delayed Birth Certificate
- State or Federal Census record
- School Record
- Foreign Passport
- Voting record
- Marriage Record
- Insurance Policy

Please note: In certain cases, additional documentation may be required.

Please complete & return form to:

New Jersey Department of Human Services
Hearing Aid Project

Address:
PO Box 715
Trenton, NJ 08625-0715
Fax 609-588-7171

Specific hearing aids prescribed for an individual may not be available at all times.
Availability is dependent upon donations of used hearing aids and funding for reconditioning.

PLEASE PRINT YOUR NAME ON THE TOP OF EACH PAGE.

Please note: You must complete all pages of the applications, including the statement/signature from the physician/licensed audiologist attesting to the necessity of a hearing aid.

1. Do you currently own a functioning hearing aid appropriate for your hearing loss? YES ☐ NO ☐

If you answered YES, DO NOT complete this application, you are NOT eligible to participate in this program.

2. Enter your name, date of birth and sex. List your Social Security number. Use CAPITAL LETTERS. Print only one letter or number in each box. List date of birth verified by Social Security.

Last Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ **Suffix (Jr., Sr., etc.)** ☐☐☐

First Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Middle Initial ☐ **Sex** **M**ale/**F**emale ☐

Social Security Number ☐☐☐ - ☐☐ - ☐☐☐☐ Date of Birth Month / Day / Year ☐☐/☐☐/☐☐☐☐

Even if your spouse is not applying, we need all of the questions answered and signatures for both of you, if married and living together.

Spouse's Last Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ **Suffix (Jr., Sr., etc.)** ☐☐☐

First Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Middle Initial ☐ **Sex** **M**ale/**F**emale ☐

Spouse's Social Security Number ☐☐☐ - ☐☐ - ☐☐☐☐ Date of Birth Month / Day / Year ☐☐/☐☐/☐☐☐☐

3. Please identify your current marital status. Please X only one box.

Married ☐ Separated* ☐ Single ☐

Widowed ☐ Divorced ☐

3b. Has your marital status changed in the last year? YES ☐ NO ☐ List the date of change ☐☐/☐☐/☐☐☐☐ Month / Day / Year

*If you are separated from your spouse, call toll free 1-800-792-9745 to request an 'Affidavit of Separation' form which MUST accompany this application.

4. List your New Jersey address (actual physical street address) below and submit proof. Is this your principal place of residence? **YES** ☐ **NO** ☐

Street Address

City State

Zip Code -

SEASONAL OR TEMPORARY RESIDENCE IN NJ, OF WHATEVER DURATION, DOES NOT QUALIFY AS YOUR PRINCIPAL PLACE OF RESIDENCE FOR THE NEW JERSEY HEARING AID PROJECT.

Submit two (2) proofs of residence with this application. Proofs must be current and dated. The date must be clearly visible and within the last 6 months.

If you use a post office box or if you have a different mailing address also complete the address below and submit proof of your actual street address with this application. If using a Power of Attorney or a care of (c/o) address, complete mailing address below and submit proof of applicant's actual street address and Power of Attorney or Guardianship Papers.

Examples of acceptable proofs of residence are:

- Public utility records and receipts (e.g. electric bill, telephone bill, etc.)
- Social Security records (e.g. Third Party Query, Form SSA-2458, etc.)
- Bills of business or professional people (e.g. doctors, pharmacies, etc.)
- Post Office Records

5. Enter your Mailing Address (if different from home address).

Address

City State

Zip Code -

6. Did you and/or your spouse file a Federal or State income tax return last year? **YES** ☐ **NO** ☐

If YES, you must submit signed copies of each return, including all schedules, with this application.

Income

7. 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 LIST CENTS.** If you or your spouse do not receive income from any of the sources listed below, place an **X** in the **NONE** box.

• Social Security Benefits (Net)	**YOU:**	**NONE** ☐	$ ☐☐ , ☐☐☐
	SPOUSE:	**NONE** ☐	$ ☐☐ , ☐☐☐
• Medicare Part B Premium (if deducted from Social Security check)	**YOU:**	**NONE** ☐	$ ☐☐ , ☐☐☐
	SPOUSE:	**NONE** ☐	$ ☐☐ , ☐☐☐
• Medicare Part D Premium (if deducted from Social Security check)	**YOU:**	**NONE** ☐	$ ☐☐ , ☐☐☐
	SPOUSE:	**NONE** ☐	$ ☐☐ , ☐☐☐
• Interest (Including tax-exempt)	**YOU:**	**NONE** ☐	$ ☐☐ , ☐☐☐
	SPOUSE:	**NONE** ☐	$ ☐☐ , ☐☐☐
• Dividends	**YOU:**	**NONE** ☐	$ ☐☐ , ☐☐☐
	SPOUSE:	**NONE** ☐	$ ☐☐ , ☐☐☐
• IRA Distributions	**YOU:**	**NONE** ☐	$ ☐☐ , ☐☐☐
	SPOUSE:	**NONE** ☐	$ ☐☐ , ☐☐☐
• Railroad Retirement	**YOU:**	**NONE** ☐	$ ☐☐ , ☐☐☐
	SPOUSE:	**NONE** ☐	$ ☐☐ , ☐☐☐
• Veterans	**YOU:**	**NONE** ☐	$ ☐☐ , ☐☐☐
	SPOUSE:	**NONE** ☐	$ ☐☐ , ☐☐☐
• Other pensions	**YOU:**	**NONE** ☐	$ ☐☐ , ☐☐☐
	SPOUSE:	**NONE** ☐	$ ☐☐ , ☐☐☐
• Annuities	**YOU:**	**NONE** ☐	$ ☐☐ , ☐☐☐
	SPOUSE:	**NONE** ☐	$ ☐☐ , ☐☐☐
• Salary (gross, before payroll deductions)	**YOU:**	**NONE** ☐	$ ☐☐ , ☐☐☐
	SPOUSE:	**NONE** ☐	$ ☐☐ , ☐☐☐
• Other income not listed above, including net rental income, workers compensation, alimony (Specify) Net Rental ☐ Alimony ☐ Worker's Comp ☐ **Other ☐	**YOU:** **SPOUSE:**	**NONE** ☐ **NONE** ☐	$ ☐☐ , ☐☐☐ $ ☐☐ , ☐☐☐

**Identify source of "Other" income: _____

8.

Signatures

I certify that to the best of my knowledge I meet the Program's eligibility requirements and will notify the Program immediately if my income rises above the legal limit, or if I move from New Jersey, or if I 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), 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 held liable for repayment of 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 above, utility information and other individually 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).

Please complete Section A. If you cannot sign, a representative may sign for you.
If someone assisted you, complete Section B as well.

SECTION A

Your Signature:	Phone Number: ( ) -
Your Spouse's Signature:	Date: / /

If you would prefer that we contact someone else if we have additional questions, please provide the person's name and a daytime phone number.

First Name:	Last Name:	Phone Number: ( ) -

SECTION B

If you are assisting someone else in completing this application, place an X in the box that describes who you are and provide your daytime phone number and address.

Family Member ☐	Attorney ☐	Other Advocate ☐	Social Worker ☐
Friend ☐	Agency ☐	Other Specify:_____ ☐	

First Name: Last Name:

Street Address: Apt #:

City: State: Zip Code:

Preparer signature:	Phone Number: ( ) -

9. To be completed by Physician or Licensed Audiologist

I have examined this applicant and determined the necessity of a hearing aid.

_____ Telephone (_____)_____
Name of Physician or Licensed Audiologist (Print)

_____
Address of Physician or Licensed Audiologist

_____ Date:_____
Signature of Physician or Licensed Audiologist