



NDHHS

Northeast Deaf and
Hard of Hearing Services, Inc.

57 Regional Drive, Concord, NH 03301
603-224-1850 x207 Voice, 603-224-0691 TTY
800-492-0407 Voice, 866-634-4764 TTY

programspec@ndhhs.org

www.ndhhs.org

**New Hampshire Telecommunication
Equipment Distribution Program
(NHTEDP)**

Application Form

Name: _____

Date of Birth: ___/___/___

Mailing Address: _____

City/State/Zip _____

Street Address: _____

City/State/Zip _____

Telephone or Fax Number: _____

Email Address: _____

Are you a resident of the State of New Hampshire? _____

Please fill in information requested below and attach proof of current income for either lending program or cost-share program (See income eligibility guidelines on page 2)

- I WISH TO APPLY FOR THE LENDING PROGRAM (Equipment is provided as long-term loan at no charge to qualifying applicants based on income eligibility criteria. NH TEDP owns equipment)
- I WISH TO APPLY FOR THE COST SHARING PROGRAM (Customer pays a portion of the 50 % of the cost and then owns the equipment if not qualified for the lending program, based on income eligibility)
- I PREFER NOT TO PROVIDE INCOME INFORMATION TO APPLY FOR THE LENDING OR COST-SHARING PROGRAM, BUT WOULD LIKE INFORMATION ON DISCOUNTED COSTS FOR THE EQUIPMENT I NEED AND OTHER SUPPORT SERVICES.

Income Information

How many people (including yourself) did you claim on your last tax return? Or, if you were claimed as a dependent by someone else, how many people did he or she claim? Write the number here: A: _____

Locate your Income Eligibility level on the chart on this page based on the number of people on Line A. Write that amount here: B: _____

Look at your last tax return for the Adjusted Gross Income. If you did not file an income tax return, list your family's annual Social Security and pension payments. Write that number here: C: _____

Is line C less than the amount on line B?
 If YES, then you meet the income eligibility requirements for this program. Please stop here and make sure you have signed the application.
 If NO, Please continue.

How much did you spend on Disability related expenses last year? You do not need to provide an itemized list of your expenses, just add it all up and write the total here: D: _____

Subtract Line D from line C. Write the total here: E: _____

Is line E less than the amount on Line B?
 If YES, then you meet the income eligibility requirements for this program. Please stop here and make sure you have signed the application.

If NO, would you like information about discounted costs for the equipment you need?

Yes No (Check one)

INCOME ELIGIBILITY CHART

Use this chart to determine the maximum allowable income level for your family size.

Family Size	Maximum Income
1	\$20,420
2	\$27,380
3	\$34,340
4	\$41,300
5	\$48,260
6	\$55,220
7	\$62,180
8	\$69,140

**Information on Disability
(please check all that apply)**

- Deaf Hard of Hearing Speech Disability Deaf Blind
 Cognitive Disability Mobility Disability Vision Disability

Please check specific difficulties you have:

- | | |
|--|--|
| <input type="checkbox"/> Hearing other people on telephone | <input type="checkbox"/> Typing |
| <input type="checkbox"/> Hearing the telephone ring | <input type="checkbox"/> Walking/getting to the telephone |
| <input type="checkbox"/> Speaking loud enough to be heard on the telephone | <input type="checkbox"/> Seeing the number or buttons on the telephone |
| <input type="checkbox"/> Holding a telephone with my hand | |

Other: _____

If you know which type of specialized communication you need, please check below:

- | | |
|---|--|
| <input type="checkbox"/> TTY | <input type="checkbox"/> Voice verification of number that I dial |
| <input type="checkbox"/> Voice Activated Phone | <input type="checkbox"/> Flashing signaler to let me know the phone rings |
| <input type="checkbox"/> Headset | <input type="checkbox"/> Loud signaler to let me know the phone rings |
| <input type="checkbox"/> Large Buttons | <input type="checkbox"/> Braille Buttons |
| <input type="checkbox"/> Remote answer for the phone | <input type="checkbox"/> Amplification to make other people's voices louder |
| <input type="checkbox"/> Amplification to make my voice louder | <input type="checkbox"/> Memory button for numbers I call often |
| <input type="checkbox"/> Emergency Alert (weather, public safety, etc.) equipment (pager, NOAA radio/other) | <input type="checkbox"/> Keys so I can type what I want to say to the other person |

Other _____

The type of equipment chosen will be determined by best matching your need according to the disability you have. Please add additional comments that would help us to determine your needs. Thank you

Would you like to be on the email list for
Northeast Deaf and Hard of Hearing Services? Yes No

Would you like to be on our mailing list for
Northeast Deaf and Hard of Hearing Services? Yes No

By signing this application, I am certifying that, to the best of my knowledge, the information provided above is complete and true.

Applicant Signature _____

Date: ___/___/___

***Please include photocopies of state issued driver license or identification, income verification documents, and social security card along with the application.**



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Dear Certifying Professional:

The NH Telecommunications Equipment Distribution Program (NHTEDP) is designed to assist people with disabilities, who cannot use conventional telephones because of their disability, to obtain adapted equipment allowing independent access to a phone. By signing this letter of certification, you are verifying that you believe your patient has such a disability thus making him/her eligible to receive adapted telephone equipment at low or no cost through our program.

If you have any questions, please contact me at Tel: (603) 224-1850, ext 207 or 1-800-492-0407; or by email at programspec@ndhhs.org

Thank you for taking the time to help your patient apply for the NHTEDP.

Yours truly,

Glenys Crane-Emerson
Program Specialist

CERTIFICATION OF DISABILITY

To be filled out by Applicant

Name: _____

Disability: _____

To be filled out by Certifying Professional*

“I certify that the person whose name appears is under my treatment and care, and in my professional opinion has a disability which makes it difficult or impossible to use a standard telephone.”

Name (please print): _____

Address: _____

Telephone Number: _____

Fax Number: _____

Signature: _____

Date: ___/___/___

* “Certifying Professional” means, as appropriate to the disability in question, any physician, physician’s assistant, audiologist, otolaryngologist, speech-language pathologist, nurse or nurse-practitioner licensed to practice in any state, or a councilor in the bureau of vocational rehabilitation of New Hampshire.

Please complete this form and mail to:

Northeast Deaf and Hard of Hearing Services, Inc
 Attn: NH Telecommunication Equipment Distribution Program (NH TEDP)
 57 Regional Drive
 Concord, NH 03301

Applications may also be faxed to (603) 856-0242