Application for North Dakota's Telecommunications Equipment Distribution Service (TEDS)

INCOME ELIGIBILITY

Your income must be *at or below* the estimate given for your household size.
If you **DO NOT** meet the income requirements below **DO NOT** fill out this application!

Please contact the ND Assistive offices at 1-800-895-4728
for other options that may be available to you.

Estimated Median Income for North Dakota Fiscal Year 2024 (Effective January 11, 2024)
**Based upon Administration for Children and Families, Office of Community Services, Division of Energy Assistance*

	Severe Hearing/ Speech/ Physical Impairment	**Deaf**
# of Persons in Household*	Estimated Median Income	150% Estimated Median Income
1	$60,240	$90,360
2	$81,760	$122,640
3	$103,280	$154,920
4	$124,800	$187,200
5	$146,320	$219,480
For each additional person, add	$21,520	$32,280

Source: U.S. Department of Health and Human Services

ND Assistive Office Locations (Please call ahead)

3240 15th Street South, Ste. B – Fargo, ND 58104 – 701-365-4728

4501 Coleman Street, Ste. 107 – Bismarck, ND 58503 – 701-258-4728

Before Submitting: Please complete pages 2-4 and sign pages 4 and 6. Applications are not considered complete until they have been signed in all required areas.

Submit completed application by mail to:
ND Assistive/ TEDS
4501 Coleman Street, Suite 107
Bismarck, ND 58503

Submit completed application by fax to:
701-365-6242 Attn: TEDS

Submit completed application by email to:
teds@ndassistive.org

For questions:

Please call 800-895-4728 or 701-365-4728 or email teds@ndassistive.org

****Alternative formats of this application are available upon request****

FOR OFFICE ONLY: Date Received:_____ Qualifies:_____ Consultant:_____ Apricot:_____

NORTH DAKOTA ASSISTIVE

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Personal Information – Required **Application Date:**

Applicant Name (First, Middle Initial, Last): _____

Date of Birth: _____ Gender: ____ Female ____ Male ____ Unknown

What is your gender identity? ___Non-Disclosure ___Female ___Male ___Transgender-Female ___Transgender-Male

Applicant Address: _____

City: _____ State: **ND** Zip: _____

Mailing Address, if different (must include): _____

County: _____ Reservation, if applicable: _____

Applicant Phone: Home (____) _____ Cell (____) _____

Applicant Email Address: _____

How did you hear about this program? ____ Brochure ____ Newspaper ____ TV Ad

____ Internet Ad ____ Radio Ad ____Word of mouth ____ Assistive website ____ Presentation

____ Doctor ____Other:_____

Demographic Information - Required

What is your ethnicity?

___Hispanic or Latino
___Not Hispanic or Latino
___Unknown

What is your race?

___American Indian/ Native Alaskan
___Asian
___Black/ African American
___Native Hawaiian/ Other Pacific Islander
___Non-Minority (White, non-Hispanic)
___White-Hispanic
___Other

What is your primary language?

___English
___Other

Do you live alone?

___No ___Yes

Do feel socially isolated?

___ No ___ Yes

Is your income at or below the national poverty level? (*see chart below*) ___ Yes ___ No

2024 HHS Poverty Guidelines (effective January 11, 2024)	
Size of Family Unit	**Poverty Guideline**
1	$15,060
2	$20,440
3	$25,820
4	$31,200
5	$36,580
For each additional person, add	$5,380

NORTH DAKOTA ASSISTIVE

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Physical Information

Do you have problems with cognition or memory? ___No ___ Yes ___ Do Not Know
Do you have problems with dexterity? ___ No ___ Yes ___ Do Not Know
Do you have problems with vision? ___ No ___ Yes ___ Do Not Know
Do you have problems with hearing? ___ No ___ Yes ___ Do Not Know
Do you have problems with speech? ___ No ___ Yes ___ Do Not Know

Equipment Questions

I have or am in the process of getting land line service? ___ No ___ Yes ___ Not Applicable
I have or am in the process of getting cell phone service? ___ No ___ Yes ___ Not Applicable
I have internet access in my home/residence? ___ No ___ Yes ___Not Applicable
I have difficulties with (check all that apply):

____ hearing on the phone
____ hearing the phone ring
____ speaking (being heard or understood) on the phone
____ holding or picking up the phone
____ seeing the numbers/ buttons on the phone
____ dialing the phone

Please describe your difficulty using the phone: _____
_____
_____

Do you currently wear a hearing aid(s)? Yes _____ No ____
Do you have a cochlear implant? Yes _____ No ____

If you know what equipment you need, please check it below:
____ Teletypewriter (TTY)
____ Amplified phone
____ Cordless phone
____ Captioned phone
____ Captioned phone with large display
____ Cell phone adaptation
____ Other _____

If you are requesting a cell phone adaptation, what make and model of cell phone do you currently have? _____

_____

NORTH DAKOTA ASSISTIVE

Application for North Dakota's Telecommunications Equipment Distribution Service (TEDS)

Eligibility (check yes or no)

- I have a severe hearing, speech, vision, and/ or physical impairment that makes using a telephone difficult. Yes____ No ____
- I currently have or am in the process of getting phone service. Yes____ No ____
- I have family income **at or under** the guidelines given below. Yes____ No ____

(*Assistive reserves the right to request a copy of applicant's federal tax return at a later date, if needed.*)

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North Dakota Fiscal Year 2024 (Effective January 11, 2024) Source: U.S. Department of Health and Human Services

Should the equipment be shipped to your home? Yes___ No___ If no, please provide the name and address to which they should be shipped.

_____

_____

_____

Professional Contact (Social Worker, Hearing Outreach, Vision Outreach, Case Manager, Medical, Etc…)

Professional Name & Role: _____

Professional Phone Number: _____

Professional Email Address: _____

Alternate Contact Person (Family, Friend, etc…)

If you would prefer us to contact someone else regarding your application, please complete the contact information below.

Contact Name and Relationship: _____

Contact Phone Number: _____

Contact Email Address: _____

The preceding facts I have provided are true and complete to the best of my knowledge. (If under 18, applicant and parent/ guardian must sign.)

_____ Date: _____

(Applicant Signature)

_____ Date:_____

(Parent/Guardian/Power of Attorney, if applicable)

Condition of Acceptance of Telecommunications Device

Use and Care
I agree to protect this equipment against damage caused by dust, dirt, weather, and physical abuse.

Damage
If the equipment is damaged, I will not try to take it apart. I will return the equipment to ND Assistive.

Theft
If the equipment is stolen, I will report it to the police. A copy of the police report must be given to ND Assistive before I can get replacement equipment.

Loss
If I lose my equipment, I must report the loss to ND Assistive. I understand that I may not receive replacement equipment.

Travel
I understand that this equipment is the property of the State of North Dakota. I can travel out of North Dakota with my equipment for short trips and vacations. Any out-of-state travel with my equipment for more than 90 days requires written permission from ND Assistive.

Change of Address
If I move to another place in North Dakota, I have ten (10) days to report my new address to ND Assistive. If I plan to move to another state, I must return the equipment to ND Assistive. This must be done before I leave North Dakota. I understand that if I do not return this equipment, I may be charged with a misdemeanor or felony theft charge according to the ND Century Code 12, 1-23-07.

State Property
I understand that this equipment is property of the State of North Dakota and as such, I will not sell it. I will not give or loan it to others not in my immediate family. If I sell my equipment, I can be criminally prosecuted.

Liability
I agree to accept responsibility for said equipment and all claims, damages, and/or expenses caused by the use or misuse of said equipment by myself or anyone else.

Denial
If I do not keep these terms of conditions of acceptance, I can be denied the privilege of having telecommunications equipment provided by the State of North Dakota.

Death
In the event of my death, the executor or other responsible party must return the equipment to ND Assistive within thirty (30) days.

Repair
ND Assistive is responsible for all reasonable expenses to maintain and repair my equipment. If my equipment is damaged, lost, or destroyed because of negligence or abuse, I must pay for replacing or repairing the equipment.

Having read the above and conditions and having them explained to me I agree to comply with all of the conditions.

_____Date: _____
(Applicant Signature)
_____Date: _____
(Parent/Guardian/Power of Attorney, if applicable)

This project is supported by funding granted through the North Dakota Department of Human Services, Aging Services Division.

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