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**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](https://aspe.hhs.gov/poverty-guidelines)

**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/ TEDS4501 Coleman Street, Suite 107Bismarck, ND 58503 | **For questions:**Please call 800-895-4728 or 701-365-4728 or email teds@ndassistive.org |
| --- | --- |
| **Submit completed application by fax to:**701-365-6242 Attn: TEDS | *\*\*\*Alternative formats of this application are available upon request\*\*\** |
| **Submit completed application by email to:**teds@ndassistive.org |  |

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

**FOR OFFICE ONLY:** Date Received:\_\_\_\_\_\_\_\_\_\_\_\_ Qualifies:\_\_\_\_\_ Consultant:\_\_\_\_\_\_\_\_ Apricot:\_\_\_\_\_

# 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 |

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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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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# 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.*)

|  | **Severe Hearing/ Speech/ Physical Impairment** | **Deaf** |
| --- | --- | --- |
| # of Persons in Household\* | Estimated Median Income | 150% Estimated Median Income |
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North Dakota Fiscal Year 2024 (Effective January 11, 2024) Source: [U.S. Department of Health and Human Services](https://aspe.hhs.gov/poverty-guidelines)

# 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)

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# 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.

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

## 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.

**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

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