

**APPLICATION FOR NORTH DAKOTA  
TELECOMMUNICATIONS EQUIPMENT  
DISTRIBUTION SERVICE**



**INCOME ELIGIBILITY**

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 2021  
(January 1, 2021 to December 31, 2021)

*\*Based upon Administration for Children and Families,  
Office of Community Services, Division of Energy Assistance  
Guidelines updated as of January 20, 2021*

	<b>Severe Hearing/ Speech/ Physical Impairment</b>	<b>Deaf</b>
3# of Persons in Household*	Estimated Median Income	150% Estimated Median Income
1	\$51,520	\$77,280
2	\$69,680	\$104,520
3	\$87,840	\$131,760
4	\$106,000	\$159,000
5	\$124,160	\$186,240
6	\$142,320	\$213,480
7	\$160,480	\$240,720
8	\$178,400	\$267,600
For each additional person, add	\$18,160	\$27,240

Source: [US Department of Health and Human Services](#)

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**ND Assistive Office Locations (Please call ahead)**

**Fargo – 3240 15<sup>th</sup> St. South, Ste. B, Fargo, ND 58104 – 701-365-4728**

**Bismarck – 4501 Coleman St., Ste. 107, Mandan, ND 58503 – 701-258-4728**

**MAILING INSTRUCTIONS**

**Before Mailing: Please complete pages 2-4 and sign pages 4 and 6.**

**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](mailto:teds@ndassistive.org)**

**For Questions:**

Please call 800-895-4728 or 701-365-4728 or email **[teds@ndassistive.org](mailto:teds@ndassistive.org)**

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**Personal Information - Required**

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

Street Address: \_\_\_\_\_

City: \_\_\_\_\_

State: ND Zip: \_\_\_\_\_

Mailing Address, if different (must include):

\_\_\_\_\_

County: \_\_\_\_\_

Reservation, if applicable: \_\_\_\_\_

Phone: Home (\_\_\_\_\_) \_\_\_\_\_

Cell (\_\_\_\_\_) \_\_\_\_\_

Email Address:

\_\_\_\_\_

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**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?

- Yes  No  Unknown

Do feel socially isolated?

- Yes  No

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

**2021 HHS Poverty Guidelines**

<b>Size of Family Unit</b>	<b>Poverty Guideline</b>
<b>1</b>	\$12,880
<b>2</b>	\$17,420
<b>3</b>	\$21,960
<b>4</b>	\$26,500
<b>5</b>	\$31,040
<b>6</b>	\$35,580
<b>7</b>	\$40,120
<b>8</b>	\$44,660
<b>For each additional person, add</b>	\$4,540

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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

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- \_\_\_ holding or picking up the phone
- \_\_\_ seeing the numbers/ buttons on the phone
- \_\_\_ dialing the phone

Please describe your difficulty using the phone:

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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 **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.)*

Estimated Median Income for North Dakota  
Fiscal Year 2021 (January 1, 2021 to December 31, 2021)

*\*Based upon Administration for Children and Families,  
Office of Community Services, Division of Energy Assistance*

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\*If more than 6 in household, call for income limit.

\*\* Guidelines were updated January 20, 2021.

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**Contact Person**

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

Contact Name and Relationship: \_\_\_\_\_

Contact Phone Number: \_\_\_\_\_

Contact 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: \_\_\_\_\_

*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, 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.

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**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.

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**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, if applicable)**

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

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