

**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>
# 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: [U.S. Department of Health and Human Services](#)

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

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

**4501 Coleman Street, Ste. 107 – Bismarck, 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

**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\*\*\**

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# APPLICATION FOR NORTH DAKOTA TELECOMMUNICATIONS EQUIPMENT DISTRIBUTION SERVICE



**Application Date:** \_\_\_\_\_

## 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: \_\_\_\_\_

## Demographic Information - Required

What is your ethnicity?

- Hispanic or Latino
- Not Hispanic or Latino
- Unknown

Do you feel socially isolated?

- No
- Yes

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

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

2021 HHS Poverty Guidelines	
Size of Family Unit	Poverty Guideline
1	\$12,880
2	\$17,420
3	\$21,960
4	\$26,500
5	\$31,040
6	\$35,580
7	\$40,120
8	\$44,660
For each additional person, add	\$4,540

What is your primary language?

- English
- Other

Do you live alone?

- No
- Yes
- Unknown

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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 **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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Source: [U.S. Department of Health and Human Services](#)

## 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/Power of Attorney, if applicable)** \_\_\_\_\_

# APPLICATION FOR NORTH DAKOTA TELECOMMUNICATIONS EQUIPMENT DISTRIBUTION SERVICE



## 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.

Updated: 6/30/2021 - G.S.

# APPLICATION FOR NORTH DAKOTA TELECOMMUNICATIONS EQUIPMENT DISTRIBUTION SERVICE



## 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.

## Mailing Instructions

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