



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 2026 (Effective January 20, 2026)

**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	\$63,840	\$95,760
2	\$86,560	\$129,840
3	\$109,280	\$163,920
4	\$132,000	\$198,000
5	\$154,720	\$232,080
For each additional person, add	\$22,720	\$34,080

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

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

Personal Information – Required – Please use only the applicant's information.

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 Presentation Medical Professional ND Assistive Website
 ND Assistive Consultant _____ Other: _____

Demographic Information - Required

What is your ethnicity?

- Hispanic or Latino
- Not Hispanic or Latino
- Unknown

Do you live alone? No Yes

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 **at or under** the national poverty level? (see chart below) Yes No

2026 HHS Poverty Guidelines (effective January 20, 2026)	
Size of Family Unit	Poverty Guideline
1	\$15,960
2	\$21,640
3	\$27,320
4	\$33,000
5	\$38,680
For each additional person, add	\$5,680

What is your primary language?

English Other _____



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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

ND Assistive now offers speech therapy services to help improve communication and related skills.
Would you like more information about this service? Yes No

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 if needed.)

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North Dakota Fiscal Year 2026 (Effective January 20,2026) 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.)

 (Applicant Signature) Date: _____

 (Parent/Guardian/Power of Attorney, if applicable) Date: _____



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Conditions 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.



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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 Conditions of Acceptance and having them explained to me I agree to comply with each 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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ND Assistive now offers occupational therapy home safety evaluations to assist with device selection, setup and training. Would you like more information about this service? No Yes