

Do you have trouble using your telephone?

The State of Minnesota, Telephone Equipment Distribution (TED) Program provides telephone equipment at **NO COST** to eligible Minnesotans with disabilities.



Equipment models may change and are not limited to what is shown here.

What is the TED Program?

The TED Program is a statewide service that provides access to phone service for those who have a hearing loss, speech or physical disability that limits their use of a standard telephone.

Equipment is provided at the discretion of the TED Program Specialist on a long-term basis at **NO COST**. All equipment is funded by a surcharge on telephone lines in Minnesota.

Telephone Equipment Distribution Program is funded through the Department of Commerce – Telecommunications Access Minnesota (TAM) and administered by the Minnesota Department of Human Services.

What if I currently have equipment from the TED Program?

Please contact us for assistance at 888-345-1725.

How do I qualify?	Yes	No	Required documents to include
1. Are you a Minnesota resident?			<ul style="list-style-type: none"> A copy of your driver's license OR A copy of your state ID card
2. Do you have telephone service?			<ul style="list-style-type: none"> A copy of your most recent phone bill (one page) OR Proof you have applied for phone service
3. Do you have a hearing loss, speech or physical disability that prevents you from using a standard phone?			<ul style="list-style-type: none"> Completed "Certification of Disability" form OR A statement of disability by a qualified professional OR A copy of a hearing aid receipt or audiogram (hearing test)
4. Does your household make less than the state median income guidelines? (See insert for current income guidelines)			<ul style="list-style-type: none"> A copy of page one of Federal Tax Form 1040 with Social Security included (no e-file) OR A recent bank statement showing direct deposits
<p>If you answered NO to any of the questions 1-4, please call the TED Program at 800-657-3663 for additional information.</p>			

How do I apply?

Complete the attached application and submit it by one of the below methods. Be sure to include documents required to show eligibility:

Mail: MN TED Program, 444 Lafayette Rd. N., St. Paul, MN 55155-3814

Email attachment: dhs.dhhsd@state.mn.us **Fax:** 651-431-7587

Applications can also be found online at: mn.gov/deaf-hard-of-hearing

What if I have additional questions?

Voice: 800-657-3663 **Email:** dhs.dhhsd@state.mn.us

Website: mn.gov/deaf-hard-of-hearing

VP: 651-964-1514 **Fax:** 651-431-7587

Or via your preferred telecommunications relay service

What if my income is too high to qualify?

The TED Program can provide information as to where to buy the telephone equipment.

If I qualify, how will I get the equipment?

The TED Program Specialist in your region will contact you to make arrangements for you to receive the equipment.

Loan Contract: Telephone Equipment Distribution (TED) Program

If you receive equipment from the TED Program, this loan contract will apply:

1. I understand that the equipment I am borrowing for telephone access belongs to the State of Minnesota; I do not own it.
2. If the equipment stops working properly, I will notify the TED Program Repair office at 888-345-1725.
3. I will take good care of the equipment to ensure it is not damaged, stolen, or lost. Damage could include a fire, cigarette smoke and/or liquid spills etc. If it is damaged, stolen, or lost, I will contact the TED Program Repair office immediately at 888-345-1725.
4. I will notify the TED Program if my address or telephone number changes.
5. I understand if any of the circumstances occur below, I will contact the TED Program:
 - I no longer live in Minnesota
 - I no longer have telephone service
 - I no longer need the equipment
 - I no longer qualify based on my income
6. I understand I cannot sell, give away, pawn or loan this equipment to anyone else. If this occurs it could result in discontinuation of services from the TED Program.
7. I understand that this agreement is binding for any additional or exchanged equipment I receive from the TED Program.
8. I understand that I may receive a survey about my experience with the telephone equipment.

Please return form signed

OFFICE USE	Date Received:	Applicant ID:
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Application: Telephone Equipment Distribution (TED) Program

Your application will be processed faster if you sign this form and send in the required verifications.

Applicant's name and contact information (Please print)

First Name	Middle Name	Last Name	Date of Birth (mm/dd/yyyy)		
Primary Phone <input type="checkbox"/> Home <input type="checkbox"/> Cell	Other Phone <input type="checkbox"/> Home <input type="checkbox"/> Cell		Email Address		
Street Address			Sex	Race	
Address Line 2		City	State MN	Zip	County
To help us with our TED Program outreach efforts, how did you hear about this program?					

Spouse's name

First Name	Middle Name	Last Name	Date of Birth (mm/dd/yyyy)
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Agreement & Signature

I agree that the facts on this application and on the enclosed information are to the best of my ability true and complete. I have read the Notice of Privacy Practices and understand my rights and responsibilities. I have read and signed the "Consent to Release Information" form. Lastly, if I receive equipment from the TED Program, I agree to the terms of the Loan Contract.

Applicant or Guardian Signature	Date
Additional family member's signature (spouse), if eligible for TED Program	Date

Certification of Disability

A qualified health or human services professional may fill this out. Examples are a medical doctor, nurse, audiologist, hearing aid dispenser, physical/occupational therapist or social worker. If you are unable to do this, please call 800-657-3663 (Voice).

To the best of my knowledge, this applicant would benefit from accessible telephone equipment.

I certify that (print name) _____ is:
(check below all that apply)

Primary Disability

- Hard of Hearing
- Deaf
- Deafblind
- Speech Disabled
- Physically Disabled

Secondary Disability

- Hard of Hearing
- Deaf
- Deafblind
- Speech Disabled
- Physically Disabled
- Vision Loss

Professional's Name (please print)	
Title	
License Number	
Telephone Number	
Email Address	
Professional's Signature	Date
Additional Comments	

OFFICE USE	Outreach Code
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Civil Rights Notice

Discrimination is against the law. The Minnesota Department of Human Services (DHS) does not discriminate on the basis of any of the following:

- race
- religion
- marital status
- sex
- color
- sexual orientation
- age
- political beliefs
- national origin
- public assistance status
- disability

Civil Rights Complaints

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by a social services agency.

Contact **DHS** directly only if you have a discrimination complaint:

Civil Rights Coordinator
Minnesota Department of Human Services
Equal Opportunity and Access Division
P.O. Box 64997
St. Paul, MN 55164-0997
651-431-3040 (voice) or use your preferred relay service

Minnesota Department of Human Rights (MDHR)

In Minnesota, you have the right to file a complaint with the MDHR if you believe you have been

- discriminated against because of any of the following:
- race
 - color
 - national origin
 - religion
 - creed
 - sex
 - sexual orientation
 - marital status
 - public assistance status
 - disability

Contact the **MDHR** directly to file a complaint:

Minnesota Department of Human Rights
Freeman Building, 625 North Robert Street
St. Paul, MN 55155
651-539-1100 (voice)
800-657-3704 (toll free)
711 or 800-627-3529 (MN Relay)
651-296-9042 (fax)
Info.MDHR@state.mn.us (email)

U.S. Department of Health and Human Services' Office for Civil Rights (OCR)

You have the right to file a complaint with the OCR, a federal agency, if you believe you have been discriminated against because of any of the following:

- race
- color
- national origin
- age
- disability
- sex
- religion

Contact the **OCR** directly to file a complaint:

Director
U.S. Department of Health and Human Services'
Office for Civil Rights
200 Independence Avenue SW, Room 509F
HHH Building
Washington, DC 20201
800-368-1019 (voice)
800-537-7697 (TDD)
Complaint Portal: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Attention. If you need free help interpreting this document, ask your worker or call the number below for your language.

ያስተውሉ፡ ይህንን ዶኩመንት ለመተርጎም እርዳታ የሚፈልጉ ከሆነ፡ የጉዳዩን ስራተኛ ይጠይቁ ወይም በሰልክ ቁጥር 1-844-217-3547 ይደውሉ።

ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اطلب ذلك من مشرفك أو اتصل على الرقم 1-800-358-0377.

သတိ။ ဤစာရွက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ သင့်လူမှုရေးအလုပ်သမား အားမေးမြန်း ခြင်းသို့ မဟုတ် 1-844-217-3563 ကိုခေါ်ဆိုပါ။

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមសួរអ្នកកាន់សំណុំរឿង របស់អ្នក ឬហៅទូរស័ព្ទមកលេខ 1-888-468-3787 ។

請注意，如果您需要免費協助傳譯這份文件，請告訴您的工作人員或撥打1-844-217-3564。

Attention. Si vous avez besoin d'une aide gratuite pour interpréter le présent document, demandez à votre agent chargé du traitement de cas ou appelez le 1-844-217-3548.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces nug koj tus neeg lis dej num los sis hu rau 1-888-486-8377.

ဟ်သ့ၣ်ဟ်သးဘၣ်တက့ၢ်. ဖဲန့ၢ်လိၣ်ဘၣ်တၢ်မၤစၢၤကလိလၢတၢ်ကကျိးထံဝဲန့ၢ်လိၣ် တီလံာ်မိတခါအံၤန့ၢ်,သံက့ၢ်ဘၣ်ပုၤဂ့ၢ်ဝဲအပုၤမၤစၢၤတၢ်လၢန့ၢ်မ့တ မ့ၢ်ကိးဘၣ် 1-844-217-3549 တက့ၢ်.

알려드립니다. 이 문서에 대한 이해를 돕기 위해 무료로 제공되는 도움을 받으시려면 담당자에게 문의하시거나 1-844-217-3565으로 연락하십시오.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ພຣີ, ຈົ່ງຖາມພະນັກງານກຳກັບການຊ່ວຍເຫຼືອຂອງທ່ານ ຫຼື ໂທໂປຣໂປທີ 1-888-487-8251.

Hubachiisa. Dokumentiin kun tola akka siif hiikamu gargaarsa hoo feete, hojjettoota kee gaafadhu ykn afaan ati dubbattuuf bilbili 1-888-234-3798.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, обратитесь к своему социальному работнику или позвоните по телефону 1-888-562-5877.

Digniin. Haddii aad u baahantahay caawimaad lacag-la' aan ah ee tarjumaadda qoraalkan, hawl wadeenkaaga weydiiso ama wac lambarka 1-888-547-8829.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, comuníquese con su trabajador o llame al 1-888-428-3438.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi nhân viên xã hội của quý vị hoặc gọi số 1-888-554-8759.

LBI (8-16)

ADA1 (2-18)



For accessible formats of this information or assistance with additional equal access to human services, write to dhs.dhhsd@state.mn.us , call 800-657-3663, or use your preferred relay service.

Keep for your own information

Notice of Privacy Practices and Tennessean Warning

Effective Date: April 1, 2018

THIS NOTICE DESCRIBES HOW PRIVATE INFORMATION INCLUDING MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

You have privacy rights under State and Federal Laws. These laws protect your privacy, but also let us give information about you to others if a law requires it. We may tell you before we give the information.

Why do we ask you for this information?

- Decide if you are eligible to get telephone equipment
- To make reports, do research and evaluate our program
- To tell you apart from other people with the same or similar name

We can use and share your health information to:

- Decide if you are eligible to get telephone equipment
- To make reports, do research and evaluate our program
- To tell you apart from other people with the same or similar name
- Help manage health care treatment you receive when referred to the DHHS Mental Health Program
- Run our organization

We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

How else can we use or share your health information?

We are allowed and required to share your information in other ways. We have to meet many conditions in the law before we can share your information for those purposes. Examples of other ways we can share information are:

- If state and federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
- For law enforcement purposes or with a law enforcement official
- In response to a court or administrative order, or in response to a subpoena.

Why do we ask you for your financial information?

We use this information only for the purposes authorized by law to verify your eligibility in the TED Program. We will not share this information with any other person or entity.

Do you have to answer the questions we ask?

Participation in our program is completely voluntary. You can refuse to answer any questions we ask during the application process. However, to receive telephone equipment we need questions answered.

What are our responsibilities?

- We must protect the privacy of your personal, health care and other private information according to the terms in this notice.
- We must follow the terms of this notice and give you a copy of it, but we may change our privacy policy. Those changes will apply to all information we have about you. The new notice will be available on request.

With whom may we share the information about you?

We will share information about you only as needed and as allowed or required by law. We may share your information with the following agencies:

- Minnesota Department of Human Services
- Minnesota Department of Commerce
- Telecommunications Access Minnesota (TAM) - Minnesota Relay Provider
- Minnesota Public Utilities Commission
- Your telephone company
- Equipment vendors the state purchases from
- Anyone else to whom the law says we must or can give the information.

You have rights regarding your information.

- You may ask if we have any information about you and get copies. If you do not understand the information, you may ask to have it explained to you.
- You may give other people permission to see and have copies of private data about you, including protected information.
- If we have collected protected information about you, we may use it only for the purposes that we have listed in this notice.
- You may question the accuracy of any information we have about you and you may ask us to correct the information about you that you think is incorrect or incomplete. Send us your concerns in writing. Tell us why the information is wrong or not complete. We may say “no” to your request, but we will tell you why in writing.
- You have the right to ask us to share with you in a certain way or in a certain place. For example, you may ask us to send private information to your work address instead of your home address. You must make this request in writing. If we find that your request is reasonable, we will grant it.
- You can ask us to restrict uses or disclosures of your protected information. Your request must be in writing. You can request to end these restrictions at any time by calling or by writing to us. We are not required to agree to your restrictions.
- You have the right to receive a record of people or organizations that we have shared your protected information with. If you want a copy of this record, you must send a request in writing to the privacy official listed below.

What if you believe your privacy rights have been violated?

You may complain if your privacy rights have been violated. You cannot be denied service or treated badly because you have made a complaint. If you believe that your data privacy has been violated, you may send a written complaint either:

- Directly to that organization, or
- To the federal Office for Civil Rights at: Office for Civil Rights U.S.
Department of Health and Human Services
233 N. Michigan Ave., Suite 240 Chicago, IL 60601
Voice Phone: 312-886-2359
FAX: 312-886-1807
TTY: 312-353-5693

If you think that the Minnesota Department of Human Services has violated your privacy rights, you may send a written complaint to the U.S. Department of Health and Human Services at the address above, or to:

Minnesota Department of Human Services
Attn: Data Complaint
PO Box 64998
St. Paul, MN 55164-0998

Whom do you contact if you need more information about privacy practices?

If you need more information about privacy practices, call the TED Program at Voice: 1-800-657-3663 or VP 651-964-1514.

Consent to Release Information

I, _____, give permission for the Telephone Equipment Distribution Program (TED) to share minimal private information to people who call on my behalf for the purpose of resolving TED equipment issues, and to family or helping professionals who call on my behalf to check the status of my application.

Purpose: I understand that my private information may not be released to people described above without this consent. Private information shared may include my name, address, phone number, current participation in the TED Program, current status of my application, problems with my telephone equipment, and anything else that is needed to resolve issues with my telephone.

Please list specific names and phone numbers of who you are allowing to have access to your private information.

I understand:

1. Why I am being asked to release this information.
2. By signing below, I give permission for the TED Program to refer my name and contact information to another program within the Deaf and Hard of Hearing Services Division in order to coordinate services.
3. That generally, I must give written consent for the TED Program to share my information.
4. If I do not consent, the information will not be released unless the law allows it.
5. If I do not give permission, TED staff may not be able to help me or services may be limited.
6. The TED Program may share my information with other programs within Deaf and Hard of Hearing Services to coordinate my services with these programs.
7. I can stop this permission in writing at any time, but it will not affect any information that has already been released.
8. The person or agency who gets my information may be able to pass it to others, and it will no longer be protected by this authorization.
9. My permission lasts until I am no longer eligible for the TED Program or I withdraw from the program.
10. I can withdraw my permission by telling the DHHS staff person who is working with me.
11. I will inform my contacts that I have given them permission to speak on my behalf to assist me in getting services.

Consumer Signature	Date
Guardian Signature	Date

Please return this form signed.

TED Program

State Median Income Guidelines

These guidelines are effective
October 1, 2019 to September 30, 2020

family size	annual gross income
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- | | |
|----|-----------|
| 1. | \$54,094 |
| 2. | \$70,738 |
| 3. | \$87,383 |
| 4. | \$104,027 |