Is it hard to use your phone due to a hearing loss, speech or physical disability?

Minnesota Access to Communication Technology (MN ACT) provides FREE phone devices to Minnesotans who qualify.

What is MN ACT?

MN ACT is a statewide service that provides phone devices for Minnesotans who have a hearing loss, speech or physical disability that limits their use of a standard telephone.

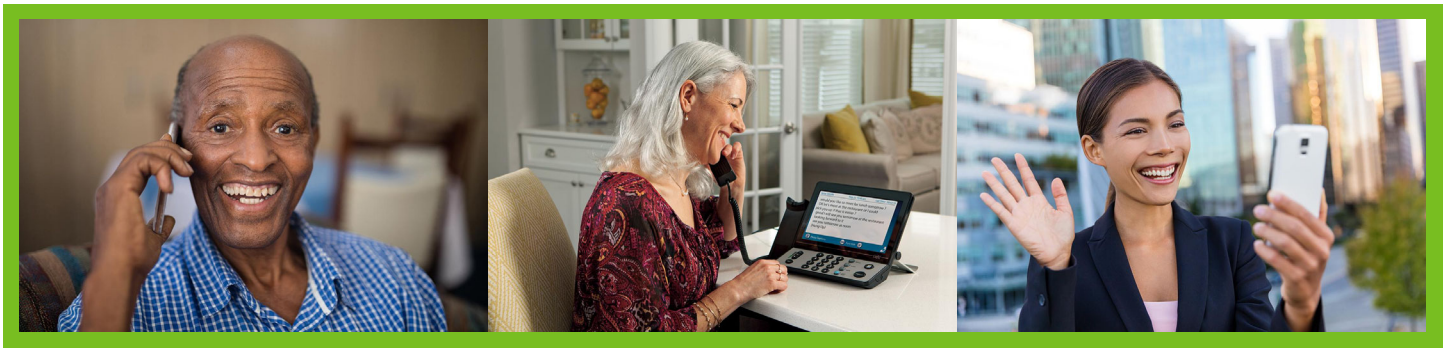
You may use these phone devices for free as long as you qualify for the program. Devices are funded by a surcharge on telephone lines in Minnesota.

Minnesota Access to Communication Technology is funded through the Department of Commerce – Telecommunications Access Minnesota (TAM) and administered by the Minnesota Department of Human Services.

What devices are provided?*	How does this device help?
Amplified phones	Volume control and tone adjustment options can help you hear and understand what the other caller is saying.
Bluetooth streamer	A Bluetooth streamer can connect directly to your hearing aid or cochlear implant, eliminating background noise and giving you more volume control.
Captioned telephones	This shows you what the other person says in text on a display screen.
Electrolarynx and voice amplifiers	If you have a speech disability these devices may help you be understood on the phone.
Ring signaling devices	Loud ringer or flashing lights help you relax knowing you won't miss a phone call.
Smartphones and tablets	With telecommunications apps a smartphone or tablet can improve access to phone calls.
Smart speakers	Uses Bluetooth technology to support hands-free phone calls if you have a physical disability.

*The device(s) you receive will depend on your needs.

DEPARTMENT OF HUMAN SERVICES
DEAF, DEAFBLIND AND HARD OF HEARING STATE SERVICES DIVISION



How do I qualify?

You:

1. Live in Minnesota,
2. Have phone service,
3. Have a hearing loss, speech or physical disability that prevents you from using the phone,
4. Have total household income less than the amount shown below for your family size:

MN ACT Income Guidelines from October 1, 2024 to September 30, 2025

Family size	Maximum annual income
1	$71,599
2	$93,629
3	$115,660
4	$137,690

What if my income is too high to qualify?

If you are not sure if you qualify, please contact us for more information. MN ACT can give you information about where to buy phone devices.

What if I have other questions?

Please contact us!

- Voice or preferred relay service: 800-657-3663
- Email: dhs.dhhsd@state.mn.us
- Website: mn.gov/deaf-hard-of-hearing
- Videophone: 651-964-1514
- Fax: 651-431-7587

How do I apply?

Complete the attached application and include:

1. Proof you live in Minnesota. A copy of your driver's license/state ID card **OR** current utility bill with your name and address.
2. Proof of phone service. A copy of your most recent phone bill listing your phone number.
3. Proof of income. 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.
4. Proof of disability. Completed "Certification of Disability" form (in the application) **OR** A letter from a qualified professional **OR** A copy of a hearing aid receipt or audiogram (hearing test).

Where do I send my application?

You may send your completed application and required documents by mail, email or fax.

Mail: MN ACT, 444 Lafayette Rd. N., St. Paul, MN 55155-0969

Email attachment: dhs.dhhsd@state.mn.us

Fax: 651-431-7587

Applications can also be found on Deaf, DeafBlind and Hard of Hearing State Services Division's website (mn.gov/deaf-hard-of-hearing).

Clear Form

DEPARTMENT OF HUMAN SERVICES

DHS-4005-ENG 9-24

DEAF, DEAFBLIND AND HARD OF HEARING STATE SERVICES

Minnesota Access to Communication Technology Application

To qualify, answer these questions:	If yes, include one of these documents:
I LIVE IN MINNESOTA. ◯ Yes ◯ No	A copy of your driver's license/state ID card **OR** current utility bill with your name and address.
I HAVE PHONE SERVICE. ◯ Yes ◯ No	A copy of your most recent phone bill listing your phone number.
I MEET THE INCOME GUIDELINES. ◯ Yes ◯ No	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.
I HAVE HEARING LOSS, A PHYSICAL OR SPEECH DISABILITY THAT MAKES IT HARD TO USE THE PHONE. ◯ Yes ◯ No	Completed "Certification of Disability" form (in the application) **OR** A letter from a from a qualified professional OR A copy of a hearing aid receipt or audiogram (hearing test).

If you answered no to any of these questions, please contact us.

Applicant's name and contact information *(please print)*

FIRST NAME	MIDDLE NAME	LAST NAME	DATE OF BIRTH

PRIMARY PHONE NUMBER	SECONDARY PHONE NUMBER
◯ Home ◯ Cell	◯ Home ◯ Cell

EMAIL ADDRESS	GENDER

RACE (optional)

☐ American Indian/Alaska Native ☐ Asian ☐ Black or African American ☐ Pacific Islander/Native Hawaiian
☐ White ☐ Other: _____

STREET ADDRESS

ADDRESS LINE 2	CITY	STATE	ZIP CODE	COUNTY

How did you hear about this program?

HOW MANY PEOPLE DO YOU LIVE WITH?

◯ I live alone ◯ I live with one other person ◯ I live with two or more other people

Loan Contract

If you receive equipment from MN ACT, this loan contract will apply:

1. I understand that the equipment I am borrowing for the telephone access belongs to the State of Minnesota; I do not own it.
2. If the equipment stops working properly, I will notify MN ACT 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 MN ACT Repair office immediately at 888-345-1725.
4. I will notify MN ACT if my address or telephone number changes.
5. I understand if any of the circumstances occur below, I will contact MN ACT:
   - 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 MN ACT.
7. I understand that this agreement is binding for any additional or exchanged equipment I receive from MN ACT.
8. I understand that I may receive a survey about my experience with the telephone equipment.

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 MN ACT, I agree to the terms of the Loan Contract.

☐ By checking this box and typing my name in the "Applicant Signature" field, I understand that I am electronically signing this form. I attest and certify that the information provided above is true and accurate. I understand that my electronic signature has the same legal effect and can be enforced in the same way as a handwritten signature. (MN Stat. §325L.07)

APPLICANT SIGNATURE (type name if signing electronically)	DATE

☐ By checking this box and typing my name in the "Additional Signature" field, I understand that I am electronically signing this form. I attest and certify that the information provided above is true and accurate. I understand that my electronic signature has the same legal effect and can be enforced in the same way as a handwritten signature. (MN Stat. §325L.07)

ADDITIONAL FAMILY MEMBER'S SIGNATURE (SPOUSE), IF ELIGIBLE FOR MN ACT (type name if signing electronically)	DATE

Certification of Disability

Bring or send this form to your 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 phone equipment.

I certify that (applicant name) _____ is:

Primary Disability (must check one)

☐ Deaf ☐ Deafblind ☐ Hard of Hearing

☐ Physically Disabled ☐ Speech Disabled

Secondary Disability

☐ Deaf ☐ Deafblind ☐ Hard of Hearing

☐ Physically Disabled ☐ Speech Disabled ☐ Vision Loss

PROFESSIONAL'S NAME (PLEASE PRINT)		TITLE
LICENSE NUMBER	PHONE NUMBER	EMAIL ADDRESS

☐ By checking this box and typing my name in the "Electronic Signature" field, I understand that I am electronically signing this form. I attest and certify that the information provided above is true and accurate. I understand that my electronic signature has the same legal effect and can be enforced in the same way as a handwritten signature. (MN Stat. §325L.07)

PROFESSIONAL'S ELECTRONIC SIGNATURE (type name)	DATE

ADDITIONAL COMMENTS

OFFICE USE	OUTREACH CODE
	7-30-2025 NW-MM

DEAF, DEAFBLIND AND HARD OF HEARING STATE SERVICES

Consent to Release Information

Please complete, sign and return

Purpose: I understand that Minnesota Access to Communication Technology staff cannot talk with others on my behalf without this consent. Private information may include my name, address, phone number, current participation in MN ACT, current status of my application, problems with my telephone equipment and anything else that is needed to resolve issues with my telephone.

I, _____ , give permission for MN ACT to share
(CLIENT NAME)
minimal private information with the following people who call about my MN ACT application and/or equipment issues on my behalf.

Please list specific names and phone numbers of who staff can talk to on your behalf below. (For example, your spouse, your adult daughter or son, social worker or someone else.) ***If you leave this blank, staff can only talk to you.**

Name	Phone number	Email address	Relationship

I understand:

1. Why I am being asked to give this information.
2. By signing below, I give permission for MN ACT to refer my name and contact information to another program within the Deaf, DeafBlind and Hard of Hearing State Services Division in order to coordinate services.
3. I must complete this form for MN ACT to share my information.
4. If I do not complete this form, the information will not be released unless the law allows it.
5. If I do not complete this form, MN ACT staff may not be able to help me or it may take longer for me to get help.
6. I can stop this permission in writing at any time, but it will not affect any information that has already been released.
7. 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.
8. My permission lasts until I am no longer eligible for MN ACT or I withdraw from the program.
9. I can withdraw my permission by telling the MN ACT staff person who is working with me.
10. I will inform my contacts that I have given them permission to speak on my behalf to assist me in getting services.

☐ By checking this box and typing my name in the "Consumer Signature" field, I understand that I am electronically signing this form. I attest and certify that the information provided above is true and accurate. I understand that my electronic signature has the same legal effect and can be enforced in the same way as a handwritten signature. (MN Stat. §325L.07)

CONSUMER SIGNATURE (type name if signing electronically)	DATE

☐ By checking this box and typing my name in the "Guardian Signature" field, I understand that I am electronically signing this form. I attest and certify that the information provided above is true and accurate. I understand that my electronic signature has the same legal effect and can be enforced in the same way as a handwritten signature. (MN Stat. §325L.07)

GUARDIAN SIGNATURE (type name if signing electronically)	DATE

Keep for your records

Notice of Privacy Practices and Tennessen 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 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 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 MN ACT at 1-800-657-3663 (voice or preferred relay service) or 651-964-1514 (videophone).

Keep for your records

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

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
540 Fairview Avenue North, Suite 201
St. Paul, MN 55104
651-539-1100 (voice)
1-800-657-3704 (toll free)
711 or 1-800-627-3529 (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:

Office for Civil Rights
U.S. Department of Health and Human Services
Midwest Region
233 N. Michigan Avenue, Suite 240
Chicago, IL 60601
Customer Response Center:
Toll-free: 1-800-368-1019
TDD Toll-free: 1-800-537-7697
Email: ocrmail@hhs.gov

Keep for your records

NO ENGLISH 

800-657-3663

Attention. If you need free help interpreting this document, call the number in the box above.

ማሳሰቢያ፦ ስለ ዶክሜንቱ ነፃ ገለፃ ከፈለጉ፣ ሠራተኛዎን ያነጋግሩ። Amharic

انتباه. إذا احتجت الى مساعدة مجانية في ترجمة هذه الوثيقة، اتصل بالرقم الموجود في المربع أعلاه. Arabic

মনোযোগ দিন। যদি আপনি বিনামূল্যে এই নথিটির ব্যাখ্যার জন্যে সহায় চান তাহলে উপরোক্ত বাক্সে থাকা নম্বরটিতে কল করুন। Bengali

သတိပြုရန်။ ဤစာတမ်းကို ဘာသာပြန်ဆိုရန်အတွက် အခမဲ့အကူအညီ လိုအပ်ပါက, အထက်ဖော်ပြပါ အကွက်ရှိ နံပါတ်ကို ခေါ်ဆိုပါ။ Burmese

ការយកចិត្តទុកដាក់។
ប្រសិនបើអ្នកត្រូវការជំនួយឥតគិតថ្លៃក្នុងការបកស្រាយឯកសារនេះ
សូមហៅទូរសព្ទទៅលេខក្នុងប្រអប់ខាងលើ។ Cambodian

注意!如果您需要免費的口譯支持,請撥打上方方框中的電話號碼。
Cantonese (Traditional Chinese)

wáŋ. héčiŋhaŋ niyé wačhíŋyAŋ wayúiyeska ki de wówapi sutá, ečíyA kiŋ wóiyawa ed ophíye waŋ. Dakota

Paunawa. Kung kailangan mo ng libreng tulong sa pag-unawa sa kahulugan ng dokumentong ito, tawagan ang numero sa kahon sa itaas.
Filipino (Tagalog)

Attention. Si vous avez besoin d’aide gratuite pour interpréter ce document, appelez le numéro indiqué dans la case ci-dessus. French

સાવધાન. જો તમને આ દસ્તાવેજને સમજવા માટે નિ:શુલ્ક મદદની જરૂર હોય, તો ઉપરના બૉક્સ પૈકીના નંબર પર કૉલ કરો. Gujarati

ध्यान दें। यदि आपको इस दस्तावेज़ की व्याख्या में निःशुल्क सहायता की आवश्यकता है, तो ऊपर बॉक्स में दिए गए नंबर पर कॉल करें। Hindi

Keep for your records

NO ENGLISH  **800-657-3663**

Lus Ceeb Toom. Yog tias koj xav tau kev pab txhais lus dawb ntawm cov ntaub ntawv no, ces hu rau tus nab npawb xov tooj nyob hauv lub npov plaub fab saum toj no. Hmong

ဟ်သူဉ်ဟ်သး. နမ့ၢ်လိဉ်ဘဉ် တၢ်မၤစၢၤကလီလၢ ကကျိးထံလံာ်တီလံာ်မိတဖဉ်အဃိ, ကိးနိဉ်ဂံၢ်လၢ အအိဉ်ဖဲတၢ်လွံၢ်နၢဉ် လၢတၢ်ဖိခိဉ်အပူၤတက့ၢ်. Karen

이 문서의 내용을 이해하는 데 도움이 필요하시면 위에 있는 전화번호로 연락해 무료 통역 서비스를 받으실 수 있습니다. Korean

تکایە سەرنج بدە. ئەگەر بۆ وەرگێڕانی ئەم بەڵگەنامەیە پێویستت بە یارمەتی بێبەرامبەرە، ئەوا پەیوەندی بەو ژمارەیەوە بکە کە لە بۆکسەکەی سەرەوەدایە Kurdish Sorani

Baldarî. Ger ji bo wergerandina vê belgeyê hewcedariya we bi alîkariya belaş hebe, ji kerema xwe bi hejmara li qutiya jorîn re telefon bikin. Kurdish Kurmanji

Hoȟpíŋ. Tóháŋ waŋží thí wíyukčaŋpi kiŋ yuhá níyuŋspe héčha čhéya, lé tkíčhuŋ kiŋ k'é náŋpa opáwiŋyaŋ. Lakota

ເອົາໃຈໃສ່. ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອຟຣີໃນການຕີຄວາມເອກະສານນີ້, ໃຫ້ໂທຫາເບີທີ່ຢູ່ໃນປ່ອງຂ້າງເທິງ. Lao

注意！如果您需要免费的口译帮助，请拨打上方方框中的电话号码。
Mandarin (Simplified Chinese)

Pa̱lɛ rɔ piny: Mi gööri luäk lɔrä kɛ luɔ̱c kä mɛmɛ, yɔtni nämbär ɛmɔ tëë nhial guäth ɛmɛ. Nuer

Mah Biz'sin'dan.
Keesh'pin nan'deh'dam'mun chi'wee'chi'goo'yan chi'nis'too'ta'man oo'weh ooshii'be'kan.
Ishi'kidoon ah'kin'das'soon ka'ooshi'bee'kadehk ish'peh'mik ka'shi ka'ka'kak. Ojibwe

Keep for your records

NO ENGLISH 

800-657-3663

Hubachiisa:-Yoo barreeffama kana hiikuuf gargaarsa bilisaa barbaaddan, lakkoofsa saanduqa armaan olii keessa jirun bilbilaa Oromo

Atenção. Se você precisar de ajuda gratuita para interpretar este documento, ligue para o número na caixa acima. Portuguese

Внимание! Если Вам нужна бесплатная помощь в переводе этого документа, позвоните по телефону, указанному в рамке выше. Russian

Pažnja. Ukoliko vam je potrebna besplatna pomoć u tumačenju ovog dokumenta, pozovite broj naveden u kvadratu iznad. Serbian

Fiiro gaar ah. Haddii aad u baahan tahay caawimo bilaash si laguugu turjumo dukumiintigan, wac lambarka ku jira sanduuqa sare. Somali

Atención. Si necesita ayuda gratuita para interpretar este documento, llame al número que aparece en el recuadro superior. Spanish

Zingatia. Iwapo unahitaji msaada usio na malipo wa kutafsiri hati hii, piga simu kwa namba iliyo kwenye kisanduku hapo juu. Swahili

ልቢ በሉ፡ ነዚ ሰነድ ንምትርጓም ነፃ ሓገዝ እንተ ደልዮም፣ በቲ ኣብ ላዕሊ ኣብ ውሽጢ ሰደቓ ተቐሚጡ ዘሎ ቁጽሪ ይደውሉ። Tigrinya

Увага! Якщо Вам потрібна безкоштовна допомога в перекладі цього документа, зателефонуйте за номером, вказаним у рамці вище. Ukrainian

Xin lưu ý: Hãy liên hệ theo số điện thoại trong ô trên nếu bạn cần bất kỳ sự hỗ trợ miễn phí nào để hiểu rõ về tài liệu này. Vietnamese

Àkíyèsí. Tí o bá nílò ìrànlówọ́ pẹ̀lú tí tú mọ̀ àkọ̀ọ́lẹ̀ yìí, pe nọ́mbà tó wà nínú àpótí tí wà ló kè. Yoruba

LB (7-24)

For accessible formats of this information or assistance with additional equal access to human services, email us at dhs.dhhsd@state.mn.us, call 800-657-3663, or use your preferred relay service.
ADA1 (3-24)