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| **[Insert Missouri-designated ETC name and/or logo]**  **Missouri Application for the Lifeline or Disabled Programs** |

Consumers meeting certain eligibility criteria are able to receive monthly discounts for voice telephony service through the Lifeline program or the Disabled program. Lifeline service offers a monthly discount of $x.xx. The Disabled program offers a $3.50 monthly discount. To apply complete this form and also submit **proof of eligibility**.

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| **Eligibility Criteria** | |
| **Lifeline Program** | **Disabled Program** |
| \_\_\_ MO HealthNet (f/k/a Medicaid)  \_\_\_ Supplemental Nutrition Assistance (Food Stamps)  \_\_\_ Supplemental Security Income  \_\_\_ Low-Income Home Energy Assistance (LIHEAP)  \_\_\_ Federal Public Housing Assistance (Section 8)  \_\_\_ National School Free Lunch Program  \_\_\_ Temporary Assistance for Needy Families (TANF)  \_\_\_ 135% of the Federal Poverty Level  *(See next page for income threshold requirements)* | \_\_\_ Veteran Administration Disability Benefits  \_\_\_ State Blind Pension  \_\_\_ State Aid to Blind Persons  \_\_\_ State Supplemental Disability Assistance  \_\_\_ Federal Social Security Disability |

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| **Applicant’s Full Name:** | **Birth Date:** | **Social Security #** *(last 4 digits)***:** | **DCN:\*** |
| **Name on Voice Service Account** *(If different from Applicant)***:** | | **Customer Contact Telephone Number:** | |
| **Customer’s Full Residential Service Address**  ***(no P.O. Boxes)*:**  Street:  City, Town, Zip: | |
| **Is this address a temporary address?** Yes / No  *(circle the appropriate response)*  *(If “yes” then must verify address every 90 days.)* | |
| **Is this address also my billing address?** \_\_\_ Yes \_\_\_ No *(If “no” please provide billing address)*: | | | |

*\*This number is assigned to program participants of MO HealthNet, LIHEAP, Food Stamps and TANF.*

**I understand the following obligations and provisions about the Lifeline and Disabled programs:**

* The Lifeline and Disabled programs are government benefit programs and that willfully making false statements to obtain the benefit can result in fines, imprisonment, de-enrollment or being barred from the program.
* Only one Lifeline or Disabled service is available per household.
* A household is defined, for purposes of the Lifeline program, as any individual or group of individuals who live together at the same address and share income and expenses.
* A household is not permitted to receive Lifeline or Disabled benefits from multiple providers or combine Lifeline and Disabled program benefits.
* Violation of the one-per-household limitation constitutes a violation of rules and will result in the subscriber’s de-enrollment from the program.
* Lifeline and the Disabled program are non-transferable benefits and the subscriber may not transfer his or her benefit to any other person.

**I CERTIFY UNDER PENALTY OF PERJURY EACH OF THE FOLLOWING:**

* I meet the eligibility criteria for the Lifeline program or the Disabled program.
* I will provide notification to my voice service provider within 30 days if for any reasons I no longer satisfy the criteria for receiving Lifeline or Disabled benefits including, as relevant, if I no longer meet the income-based or program-based criteria for receiving Lifeline or Disabled support, I receive more than one Lifeline or Disabled benefit, or another member of my household is receiving a Lifeline or Disabled benefit.
* If I move to a new address I will provide that new address to my voice service provider within 30 days.
* If I have a temporary residential address then I will be required to verify my address with my voice service provider every 90 days.
* My household will receive only one Lifeline or Disabled service and, to the best of my knowledge, my household is not already receiving a Lifeline or Disabled service.
* I acknowledge the obligation to re-certify my continued eligibility for Lifeline or Disabled benefits at any time and failure to re-certify my continued eligibility will result in de-enrollment and the termination of Lifeline or Disabled benefits.
* I consent to providing my name, telephone number and address to the Universal Service Administrative Company for the purpose of verifying I do not receive more than one Lifeline benefit. I also consent to sharing my account information with the Federal Communications Commission and Missouri Public Service Commission who oversee and administer the Lifeline or Disabled programs.

\_\_\_\_\_\_ I certify I have \_\_\_\_\_individuals in my household.

*(Initial and complete only if qualifying under income threshold.)*

**The information supplied on this form is true and correct.**

**I acknowledge providing false or fraudulent information to receive Lifeline or Disabled benefits is punishable by law.**

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**Signature of Customer** **Date**

**Submit a completed signed form and proof of eligibility.**

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| Annual Income Thresholds for Meeting 135% of Federal Poverty Level (Based on Household Size) | | | | | | | | |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | Each add’l person |
| $15,755 | $21,236 | $26,717 | $32,198 | $37,679 | $43,160 | $48,641 | $54,122 | + $5,481/person |

*Acceptable documentation for meeting the criteria of 135% of the federal poverty level includes: a copy of prior year’s state or federal tax return; paycheck stub (three consecutive months); a statement of benefits for Social Security, Veterans Administration, retirement/pension or Unemployment/Workmen’s Compensation; or other legal documents showing current income (e.g. divorce decree, child support award). Any documentation must cover a full year or three consecutive months within the previous twelve months.*

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| **Company Use Only:**  **I hereby attest the applicant presented acceptable proof of eligibility:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Print name of company official Signature Date** |

**[If desired, insert Missouri-designated ETC name, logo, or contact information.]**