

If you have already provided this information and have no changes, it is not necessary to resubmit.

ACCOUNT INFORMATION:

Name(s): _____

Service Address: _____

Billing Address: _____

Phone: _____

Cell: _____

Additional Contact Name:

Contact Address: _____

Contact Phone No: _____

Please indicate:

- Send copy of bill to additional contact name.
- Notify additional contact name of overdue bills:

Landlord: _____

Address: _____

Phone: _____

SENIORS: (65 and older- include proof of age)

Birthdate: _____

LOW INCOME: Household income must be less than 150% of poverty level per USDHHS. See chart for guidelines. If qualified, please provide copy of recent W2.

No in Family	Gross Income Must Be Less Than The Following:
1	\$17,820
2	\$24,030
3	\$30,240
4	\$36,450
5	\$42,660
6	\$48,870
7	\$55,095
8	\$61,335

If you answer yes to any of the following, please provide verification:

Food Stamps: Yes _____ No _____

Medicaid: Yes _____ No _____

State Emergency Relief: Yes _____ No _____

MEDICAL EMERGENCY/CRITICAL CARE:

Name of patient: _____

Type of Equipment being used: _____

Duration of Use: _____

Beginning Date: _____

Ending Date: _____

Please provide documentation from Doctor/Public health official stating type of equipment and that interruption of service would be immediately life threatening.

MILITARY: (Please provide verification)

Active duty status: Yes _____ No _____
Is household income reduced due to active status:

Yes _____ No _____

Do you require shut-off protection:

Yes _____ (Payment plan is required)

No _____

NOTE: If you have already completed this form and no changes have occurred in your status, an additional form is not necessary.