

Appendix F. Discount Rate Applications

Income-eligible customers can be placed on a discount rate by submitting an application to their gas and/or electric utility. Discount rate applications for almost all Massachusetts gas and electric utilities can be found online. The only exception is Berkshire Gas, which doesn't have an application. Customers seeking to be placed on the discount rate should call to apply. The list below includes links for those utility discount rates applications available online, and is followed by sample discount rate forms.

Berkshire Gas: Please call (800) 292-5012 to apply for the discount rate.

Columbia Gas (Bay State Gas): Discount rate application must be filled out and submitted online. It is not available for download. Find out more [here](#).

National Grid (gas): Information about the discount rate can be found [here](#). The discount rate application is available [online](#) for download.

National Grid (electric): Information about the discount rate can be found [here](#). The discount rate application is available [online](#) for download.

New England Gas: Discount rate application is available for download [here](#).

NSTAR (gas and electric): Discount rate application must be filled out and submitted online. It is not available for download. Find out more [here](#).

Unitil/Fitchburg Gas and Electric Light Company: Discount rate application is available for download [here](#).

WMECO: Discount rate applications, in English and Spanish, are available for download [here](#).

Aviso importante. Faça favor de traduzir imediatamente.
Avis important. Veuillez traduire immédiatement.
Aviso importante: por favor tradúzcalo inmediatamente.

Important information and Enrollment Forms for Customers Requesting Protected Status

Age 65 and Older Protection

In Massachusetts, if you and everyone living in your home are 65 years old or older **OR** if everyone on the residence is 65 years or older and has a minor also in the residence, you are eligible for special protection from the termination of your natural gas service as a result of an arrears on your natural gas account.

Other Protections

Your natural gas service cannot be shut off, or will be restored, if you provide certification to New England Gas Company that you are unable to pay any overdue bill because of financial hardship, and;

- Someone living in your home is seriously ill; or
- A child under 12 months old lives in your home; or
- Between November 15th and March 15th natural gas is used as your primary heating fuel and your service was not shut off for non payment before November 15th.

Third Party Notification Service

New England Gas Company offers customers a service known as “Third Party Notification.” This service allows New England Gas Company, with your permission, to notify a friend, relative or neighbor if your gas bill is overdue. This service is particularly helpful for those who would like a reminder to pay their bill or who may need help managing their bills. The person you select as your “third party” is not responsible for paying your bill, only for reminding you to pay it if it becomes overdue. To enroll in this service, please complete and mail the Third Party Notification Service request form (*see addresses, phone numbers and mailing instructions listed on each form*).



Financial Hardship Certification Request Form *(certification required quarterly)*

Please check one:

- I am a Massachusetts resident with a financial hardship and there is a seriously ill resident living at the address listed below. *(please complete the Doctor Certification Form)*
- I am a Massachusetts resident with a financial hardship and there is a child under 12 months old who is a resident living at the address listed below. *(please include photocopy of child's birth certificate with this form)*
- I am a Massachusetts resident with a financial hardship and my service provides heat or operates the heating system and has not been shut off for nonpayment before November 15th. Protection applies for winter moratorium period. *(please complete the form below)*

If you are claiming "financial hardship" under Massachusetts General Law, Chapter 164, Section 124F, please provide the following information and return this form to the address listed below. Pursuant to 220 CMR Chapter 25.03(4), customers claiming financial hardship must recertify their eligibility with the Company on a quarterly basis.

Customer Name		Phone Number	
Account Number	Premise Number	Social Security Number <i>(optional)</i>	
Customer Address			
City	State	Zip	
Number of People in Household	Total Annual Income <i>(all sources)</i>		
Signature	Date		

Please mail completed form to: New England Gas Company, Special Protections, P.O. Box 911, Fall River, MA 02722



Elderly (age 65 or older) Protection Certification Form *(certification required annually)*

Customer Name		Phone Number	
Account Number	Premise Number	Social Security Number <i>(optional)</i>	
Customer Address			
City	State	Zip	
Names of other adult residents in household:			
Name	Social Security Number <i>(optional)</i>	Birth Date	
Name	Social Security Number <i>(optional)</i>	Birth Date	
Name	Social Security Number <i>(optional)</i>	Birth Date	
I hereby certify that my household meets the requirements for Elderly Protection and that all the information I've provided is true and accurate. I hereby certify that I am the customer of record for the account specified above, and that I, and every other resident of my household are 65 years of age or older.			
Signature	Date		

Please mail completed form to: New England Gas Company, Special Protections, P.O. Box 911, Fall River, MA 02722



Third Party Notification Service Request Form *(certification required annually)*

Customer Name _____ Phone Number _____

Account Number _____ Premise Number _____

Customer Address _____

City _____ State _____ Zip _____

Party to be notified:

Name _____ Phone Number _____

Relationship to Customer *(optional)* _____ Address _____

City _____ State _____ Zip _____

Signature of Customer _____ Date _____

Signature of Party to be Notified _____ Date _____

By signing above, customer and party to be notified give consent to New England Gas Company to arrange "Third Party Notification" service.

Please mail completed form to: New England Gas Company, Special Protections, P.O. Box 911, Fall River, MA 02722



Doctor Certification Form *(re-certification quarterly for serious illness; every 6 months for chronic illness)*

In order to qualify for protected status due to your illness, you are required to have your doctor certify your status by completing the form below. Mail or bring this form to your doctor. Both you and your doctor must sign this form and he or she must return it to us according to the mailing instructions at the bottom of this form.

Instructions to Doctor:

Your patient has requested protected status (he or she has a serious illness) as a customer of New England Gas Company. After obtaining the patient's signature (see below), please provide the following information including your signature:

Nature of Illness _____ Chronic / Non-chronic _____

Doctor's Name *(please print)* _____ Doctor's Signature _____ Date _____

Doctor's Address _____

Name and Age(s) of Child(ren) under 12 Months of Age _____

Customer's (Patient's) Name *(please print)* _____ Customer's (Patient's) Signature _____

Customer's (Patient's) Address _____

Please mail completed form to: New England Gas Company, Special Protections, P.O. Box 911, Fall River, MA 02722



Supplemental Security Income (SSI) Recipients *(certification required annually)*

New England Gas Company offers a low-income discount rate to customers who qualify and receive Supplemental Security Income (SSI) as administered by the Social Security Administration. (This is not the same as Social Security Income.)

___ I am presently a customer of record of New England Gas Company (your name appears on the bill)

___ I am presently receiving Supplemental Security Income (SSI)

Customer Name

Phone Number

Account Number

Premise Number

Social Security Number

Customer Address

City

State

Zip

I authorize the Social Security Administration to disclose to New England Gas Company that I am currently a recipient of Supplemental Security Income (SSI) benefits. This information is to be used solely to determine my eligibility for New England Gas Company's SSI discount rate.

Signature of Customer

Date

Please mail completed form to: New England Gas Company, Special Protections, P.O. Box 911, Fall River, MA 02722

OFFICIAL USE ONLY Qualifies for SSI: ___ Yes ___ No

ARREARAGE MANAGEMENT PROGRAM (AMP)

New England Gas's Arrearage Management Program (AMP) provides financial assistance to eligible low-income customers with active accounts that have outstanding bills in arrears.

Under the AMP program, eligible low-income customers may qualify for forgiveness of past due utility bills and program participants receive monthly credits to their past due account once all the program requirements have been met (Some restrictions may apply). Participation in the Arrearage Management Program and forgiveness of the past due balance is extended only once.

Eligibility

The following eligibility guidelines must be met to qualify for the Arrearage Management Program (AMP):

- Must be the customer of record at the premise (not a landlord account)
- The customer of record must reside at the location where the utility service is provided
- Must have outstanding bills with a minimum of \$ 300.00 in arrears and sixty (60) days past due
- Must be eligible for the company's low-income discount rate
- Must not be shutoff for non-payment

How to Apply

You may apply for this program by calling the Contact Center at (800) 544-4944.

AMP Benefit

The AMP program provides forgiveness of all past due bills of eligible low-income residential customers. AMP forgiveness credits are capped at \$1,200.00 annually and \$100.00 monthly.

Program Requirements

Customers approved for the AMP program must:

1. Enter into a monthly payment plan that includes:
 - a. Current bill amount
 - b. Future projected bills for the term of the payment plan less any projected fuel assistance payments
2. Pay the monthly amount agreed to in order to receive the monthly AMP credit
3. Apply for, and agree to participate in, all other financial assistance programs available (e.g. fuel assistance, weatherization/conservation, etc.).

Failure to pay the monthly amount agreed to will result in termination of the payment agreement, and any remaining AMP benefit will be forfeited. The AMP payment plan may be reinstated if all missed payments along with the current payments are made.

Special Protections

Customer Service

It is the customer's responsibility to contact New England Gas Company to apply for protected status. To make a payment arrangement, or, for more information about the protections listed in this brochure, please contact us at **(800) 544-4944**.

Hearing & Speech Impaired: **Dial 711**

Gas Leak Emergency Number: **(800) 936-7000**

Web Site: **www.negasco.com**

Hours

New England Gas Company's customer service telephone hours are 8:00am to 4:30pm, Monday through Friday.

Low Income Home Energy Assistance Program (LIHEAP) Agencies

Fall River

Citizens for Citizens
(508) 679-0041

North Attleboro

Self Help
(508) 226-4192

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Customer Name		Phone Number	
Account Number	Premise Number	Social Security Number <i>(optional)</i>	
Customer Address			
City	State	Zip	
Number of People in Household	Total Annual Income <i>(all sources)</i>		
Signature	Date		

Please mail completed form to: New England Gas Company, Special Protections, P.O. Box 911, Fall River, MA 02722



Elderly (age 65 or older) Protection Certification Form *(certification required annually)*

Customer Name		Phone Number	
Account Number	Premise Number	Social Security Number <i>(optional)</i>	
Customer Address			
City	State	Zip	
Names of other adult residents in household:			
Name	Social Security Number <i>(optional)</i>	Birth Date	
Name	Social Security Number <i>(optional)</i>	Birth Date	
Name	Social Security Number <i>(optional)</i>	Birth Date	
I hereby certify that my household meets the requirements for Elderly Protection and that all the information I've provided is true and accurate. I hereby certify that I am the customer of record for the account specified above, and that I, and every other resident of my household are 65 years of age or older.			
Signature	Date		

Please mail completed form to: New England Gas Company, Special Protections, P.O. Box 911, Fall River, MA 02722



Third Party Notification Service Request Form *(certification required annually)*

Customer Name _____ Phone Number _____

Account Number _____ Premise Number _____

Customer Address _____

City _____ State _____ Zip _____

Party to be notified:

Name _____ Phone Number _____

Relationship to Customer *(optional)* _____ Address _____

City _____ State _____ Zip _____

Signature of Customer _____ Date _____

Signature of Party to be Notified _____ Date _____

By signing above, customer and party to be notified give consent to New England Gas Company to arrange "Third Party Notification" service.

Please mail completed form to: New England Gas Company, Special Protections, P.O. Box 911, Fall River, MA 02722



Doctor Certification Form *(re-certification quarterly for serious illness; every 6 months for chronic illness)*

In order to qualify for protected status due to your illness, you are required to have your doctor certify your status by completing the form below. Mail or bring this form to your doctor. Both you and your doctor must sign this form and he or she must return it to us according to the mailing instructions at the bottom of this form.

Instructions to Doctor:

Your patient has requested protected status (he or she has a serious illness) as a customer of New England Gas Company. After obtaining the patient's signature (see below), please provide the following information including your signature:

Nature of Illness _____ Chronic / Non-chronic _____

Doctor's Name *(please print)* _____ Doctor's Signature _____ Date _____

Doctor's Address _____

Name and Age(s) of Child(ren) under 12 Months of Age _____

Customer's (Patient's) Name *(please print)* _____ Customer's (Patient's) Signature _____

Customer's (Patient's) Address _____

Please mail completed form to: New England Gas Company, Special Protections, P.O. Box 911, Fall River, MA 02722



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New England Gas Company offers a low-income discount rate to customers who qualify and receive Supplemental Security Income (SSI) as administered by the Social Security Administration. (This is not the same as Social Security Income.)

___ I am presently a customer of record of New England Gas Company (your name appears on the bill)

___ I am presently receiving Supplemental Security Income (SSI)

Customer Name

Phone Number

Account Number

Premise Number

Social Security Number

Customer Address

City

State

Zip

I authorize the Social Security Administration to disclose to New England Gas Company that I am currently a recipient of Supplemental Security Income (SSI) benefits. This information is to be used solely to determine my eligibility for New England Gas Company's SSI discount rate.

Signature of Customer

Date

Please mail completed form to: New England Gas Company, Special Protections, P.O. Box 911, Fall River, MA 02722

OFFICIAL USE ONLY Qualifies for SSI: ___ Yes ___ No

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Eligibility

The following eligibility guidelines must be met to qualify for the Arrearage Management Program (AMP):

- Must be the customer of record at the premise (not a landlord account)
- The customer of record must reside at the location where the utility service is provided
- Must have outstanding bills with a minimum of \$ 300.00 in arrears and sixty (60) days past due
- Must be eligible for the company's low-income discount rate
- Must not be shutoff for non-payment

How to Apply

You may apply for this program by calling the Contact Center at (800) 544-4944.

AMP Benefit

The AMP program provides forgiveness of all past due bills of eligible low-income residential customers. AMP forgiveness credits are capped at \$1,200.00 annually and \$100.00 monthly.

Program Requirements

Customers approved for the AMP program must:

1. Enter into a monthly payment plan that includes:
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3. Apply for, and agree to participate in, all other financial assistance programs available (e.g. fuel assistance, weatherization/conservation, etc.).

Failure to pay the monthly amount agreed to will result in termination of the payment agreement, and any remaining AMP benefit will be forfeited. The AMP payment plan may be reinstated if all missed payments along with the current payments are made.

Special Protections

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Gas Leak Emergency Number: **(800) 936-7000**

Web Site: **www.negasco.com**

Hours

New England Gas Company's customer service telephone hours are 8:00am to 4:30pm, Monday through Friday.

Low Income Home Energy Assistance Program (LIHEAP) Agencies

Fall River

Citizens for Citizens
(508) 679-0041

North Attleboro

Self Help
(508) 226-4192

National Grid's Discount Rate

Significant savings are available to eligible customers.

- Yes, I would like to apply for National Grid's Low Income Discount Rate. I authorize the agency(s) providing my benefits to release information to National Grid for the purposes of enrollment and annual recertification for the Discount Rate and to notify the company if my benefits are discontinued. I also understand that I must notify National Grid if my benefits are discontinued.

National Grid Account #

Social Security #:

Name _____ Telephone # _____

Address _____

City _____ State _____ ZIP _____

I receive benefits from the following program(s):

- | | |
|---|--|
| <input type="checkbox"/> Emergency Aid to Elders Disabled and Children (EAEDC)* | <input type="checkbox"/> Public or subsidized housing* |
| <input type="checkbox"/> Food Stamps* | <input type="checkbox"/> School Breakfast or Lunch Program (Free)* |
| <input type="checkbox"/> Fuel Assistance | <input type="checkbox"/> Supplemental Security Income (SSI)* |
| <input type="checkbox"/> Head Start* | <input type="checkbox"/> Transitional Aid to Families with Dependent Children (TAFDC)* |
| <input type="checkbox"/> MassHealth (Medicaid)* | <input type="checkbox"/> Veterans' Service Benefits* |
| | <input type="checkbox"/> Veterans Non-Service Pension/DIC* |

*Please provide proof of benefits (ex. a copy of the certifying agency's acceptance letter).

I certify that all of the information provided on this application is true. I receive benefits from the program(s) indicated and the National Grid residential account above is in my name and my income does not exceed 200% of the Federal Poverty Guideline.

Signature _____ Date _____

This program is offered by National Grid. Please allow 8 weeks for verification and processing. Once accepted, the rate code on your bill will change to R-2 if you do not heat with gas, or R-4 if you do heat with gas.

If you have any questions about the program, please contact us at the Customer Assistance telephone number on your bill. Mail this completed application to:

National Grid, Massachusetts Discount Rate, One MetroTech Center, 2nd Floor, Brooklyn, NY 11201

AVISO IMPORTANTE: La información en este aplicación puede ser de beneficio para usted. Por favor asegurese de que ésta sea traducida cuanto antes.

nationalgrid

The power of action.™

You May Qualify for the Residential Electric or Gas Discount Rate

Below are eligibility guidelines for 2012-2013,
based on the number of household members
and their combined gross annual income.

# of Household Members*	Gross Annual Income
1	\$ 31,271
2	\$ 40,893
3	\$ 50,515
4	\$ 60,137
5	\$ 69,759
6	\$ 79,381
7	\$ 81,185
8	\$ 82,989

* For eligibility of families with more
than eight members, please call Unitil
at (888) 301-7700.



Customer Service Center
5 McGuire Street
Concord, NH 03301

1-888-301-7700
www.unitil.com

You May Qualify for the Residential Electric or Gas Discount Rate



Electric or Gas Residential Discount Rate

Unitil offers a Discount Rate Program for certain income eligible customers. You may qualify for the Discount Rate if you meet the following criteria.

1. Your household income does not exceed 60% of the state median income.
2. You are a residential customer (primary dwelling, only).
3. You are the head of your household or principal wage earner.
4. The electric or gas bill is in your name.

AND

5. You are currently receiving benefits under one or more of the following programs: *(Please check the benefits you receive below. Check all that apply)*

- Transitional Aid to Families with Dependant Children (TAFDC)
- Emergency Aid to Elderly, Disabled and Children (EAEDC)
- SNAP
- Mass Health (DMA)
- Mass Health (DTA)
- Mass Health (Mass Comm for the Blind)
- School Breakfast/Lunch (Free)
- Fuel Assistance
- Veteran Chapter 115
- Veterans Non-Service Pension/DIC
- Head Start
- Supplemental Social Security (SSI)
- Public/Subsidized Housing

If you have questions, please contact our Customer Service Center at (888) 301-7700, or visit us at www.unitil.com



I would like to apply for:

- Residential Electric Discount Rate*
- Residential Gas Discount Rate*

*Customers who qualify for these programs will be required to certify their eligibility each year.

Please complete this form and return, along with verification documentation, to:

*Unitil Customer Service Center
5 McGuire Street
Concord, NH 03301-4622*

Name: _____

Account No. _____

Mailing Address:

Telephone No. _____

Description of Benefits:

*I certify each of the following to be true:
I receive assistance benefits under the program(s) mentioned above. I receive a Unitil bill and it is in my name. I authorize the agency responsible for benefit(s) being received to release information on this application to Unitil. I authorize the administrator of the program to notify Unitil in the event that my benefits are terminated. I also understand that I am required to notify Unitil that my benefits have stopped.*

Signature: _____

Date: _____

Western Massachusetts Electric Company

Discount Rate Application



**Western Massachusetts
Electric**

A Northeast Utilities Company

Significant savings are available to eligible electric customers.

Yes, I would like to apply for WMECo's residential discount rate. I authorize the agency(s) providing my benefits to release information to WMECo for enrollment and annual re-certification for the discount rate and to notify WMECo if my benefits are discontinued. I also understand that I am required to notify WMECo if my benefits are discontinued.

WMECo Account Number:

Social Security Number:

Name: _____ Telephone: _____
(Last) (First) (Middle initial)

Address: _____

City: _____ Zip: _____

Eligibility criteria for the discount rate:

- You are a residential customer (primary residence only).
- Your WMECo bill is in your name.
- You are income-eligible for the Low-Income Home Energy Assistance Program (LIHEAP), also known as Fuel Assistance.
- Your household income does not exceed 60 percent of the estimated state median income.
- You are currently receiving benefits under a means-tested program (check all that apply below)

I currently receive one or more benefits from the following programs:

- | | |
|---|---|
| <input type="checkbox"/> Fuel Assistance* | <input type="checkbox"/> Supplemental Security Income (SSI) |
| <input type="checkbox"/> MassHealth* | <input type="checkbox"/> Emergency Assistance for the Elderly, Disabled, & Children (EAEDC) |
| <input type="checkbox"/> Public/Subsidized Housing* | <input type="checkbox"/> Transitional Aid to Families with Dependent Children (TAFDC) |
| <input type="checkbox"/> Head Start* | <input type="checkbox"/> Veterans' Service Benefits (Chapter 115)* |
| <input type="checkbox"/> SNAP (Food Stamps) | <input type="checkbox"/> Veterans DIC Surviving Parent or Spouse* |
| <input type="checkbox"/> School Breakfast/Lunch Program | <input type="checkbox"/> Veterans Non-Service Disability Pension* |

*Please provide proof of benefits (ex. a copy of the certifying agency's acceptance letter).

I certify that all of the information provided on this application is true. I receive benefits from the program(s) indicated and the WMECo residential account above is in my name and I am income-eligible.

Signature: _____

Please mail this application and copies of your eligibility documentation to: WMECo Customer Service Center
P.O. Box 2010
West Springfield, MA 01090-2010

If you have any additional questions, please call our Customer Service Department Monday – Friday, 7:00 a.m. – 7:00 p.m. or Saturday, 10:00 a.m. – 3:30 p.m. at 413-781-4300 (within the Springfield calling area) or 800-286-2000 (outside of the Springfield calling area). Or visit us at www.wmeco.com.

This information is important. Please have it translated.

Western Massachusetts Electric Company

Solicitud Para Descuento de Tarifa



**Western Massachusetts
Electric**

A Northeast Utilities Company

Ahorros significativo de electricidad disponibles para clientes elegibles.

Si, me gustaría solicitar para el descuento de tarifa residencial de WMECO. **Autorizo a la agencia(s) hacer pública mi información personal a WMECO para inscribirme y recibir la certificación anual para el descuento de tarifa y notificar a WMECO si mis beneficios son descontinuados.**

Número de Cuenta de WMECO:

Número de Seguro Social:

Nombre: _____
(Apellido) (Primer Nombre) (Inicial del Segundo Nombre)

Teléfono: _____

Dirección: _____

Ciudad: _____ Código Postal: _____

Criterio de elegibilidad para el descuento de tarifa:

- Ser cliente residencial (sólo residencia primaria).
- La factura de WMECO debe estar a su nombre.
- Tener un ingreso elegible para el programa de Asistencia de Energía para familias de bajos ingresos (Low-Income Home Energy Assistance Program, LIHEAP), también conocido como Asistencia de Energía (Fuel Assistance).
- Su ingreso familiar no debe exceder el 60 por ciento del ingreso promedio del estado.
- Debe recibir actualmente los beneficios de uno de los programas mencionados abajo y verificar su ingreso (marque todos los que recibe)

Actualmente recibo uno o más beneficios de los siguientes programas:

- | | |
|---|---|
| <input type="checkbox"/> Fuel Assistance* | <input type="checkbox"/> Supplemental Security Income (SSI) |
| <input type="checkbox"/> MassHealth* | <input type="checkbox"/> Emergency Assistance for the Elderly, Disabled, & Children (EAEDC) |
| <input type="checkbox"/> Public/Subsidized Housing* | <input type="checkbox"/> Transitional Aid to Families with Dependent Children (TAFDC) |
| <input type="checkbox"/> Head Start* | <input type="checkbox"/> Veterans' Service Benefits (Chapter 115)* |
| <input type="checkbox"/> SNAP (Food Stamps) | <input type="checkbox"/> Veterans DIC Surviving Parent or Spouse* |
| <input type="checkbox"/> School Breakfast/Lunch Program | <input type="checkbox"/> Veterans Non-Service Disability Pension* |

*Proporcione por favor prueba de beneficios (ex. una copia de la carta de la aceptación de agencia que certifica).

Certifico que toda la información proveída en esta aplicación es verdadera. Recibo beneficios del programa (s) indicado arriba y la cuenta residencial de WMECO está a mi nombre y tengo ingresos elegibles.

Firma: _____

Por favor envíe por correo esta solicitud y copias de su documentación elegible a: WMECO Customer Service Center
P.O. Box 2010
West Springfield, MA 01090-2010

Si tiene alguna pregunta, por favor lláme a nuestro departamento de Atención al Cliente de Lunes a Viernes, 7:00 a.m. – 7:00 p.m. o Sábados, 10:00 a.m. – 3:30 p.m. al 413-781-4300 (en el área de Springfield) o 800-286-2000 (fuera del área de Springfield). También puede visitarnos al www.wmeco.com.