

MISSOURI

Application for Low Income or Disabled Discounts

You may qualify for a discount on your monthly telephone bill if you or a dependent residing in your household receives low income or disability benefits under certain programs. The discount varies between \$3.50 & \$13.50 depending on your local voice provider and the type of program. The programs that qualify for low income benefits or disability benefits are listed below.

If you or a dependent residing in your household receives benefits from one or more of the programs listed below, please check all that apply, complete the remainder of the form, and return it to your local voice provider with documentation verifying participation in at least one program. Documentation may include a benefit card or a letter to you or a dependent residing in your household from the federal, state, or local agency that administers the qualifying program.

LOW INCOME PROGRAMS

- MO HealthNet (f/k/a Medicaid)
- Food Stamps
- Supplemental Security Income
- Low-Income Home Energy Assistance Program (LIHEAP)
- Federal Public Housing Assistance or Section 8
- National School Free Lunch Program
- Temporary Assistance for Needy Families

DISABLED PROGRAMS

- Veteran Administration Disability Benefits
- State Blind Pension
- State Aid to Blind Persons
- State Supplemental Disability Assistance Payments Administered by the Family Support Division
- Federal Social Security Disability
- Federal Supplemental Security Income

I certify under penalty of perjury that I or a dependent residing in my household currently receives benefits from at least one of the programs listed above. I agree to notify my local voice provider immediately if I or a dependent residing in my household ceases to participate in these programs. I direct and authorize any agency administering these qualifying programs to confirm and provide verifying documents to the Missouri Public Service Commission, or any delegate thereof, of current participation in a program. I confirm local voice service discounts under the low income or disabled programs are limited to one per household.

Name of Beneficiary (please print)	Signature of Beneficiary or Guardian/Date
Name Listed on Local Voice Service Account (please print)	Signature of Local Voice Subscriber
Address	Telephone Number
City, State, Zip	

I _____ hereby attest that the supporting program documentation was presented and verified.
Company Representative (please print)

Signature	Title	Date
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