**TELEPHONE ASSISTANCE APPLICATION FORM – NEW MEXICO**

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| Member Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Lifeline Telephone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Physical Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_NM\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_Mailing Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_NM\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Last 4 digits of SSN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone Company**: La Jicarita Rural Tele. Coop**. No. of people living in your household: \_\_\_\_\_\_\_\_\_\_**COMPLETE SECTION 1 OR 2, BUT DO NOT FILL OUT BOTH** |
| **SECTION 1.** I, or a member of my household, currently participate in the following program(s):Check all that applies and attach a copy of acceptance letter to the applicable program.

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|  Medicaid Supplemental Security Income (SSI) Federal Public Housing Assistance  |  Supplemental Nutrition Assist. Program Veteran's Pension or Survivor's Pension  |

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| **SECTION 2.** I do not receive benefits from any of the programs listed above, BUT my income is at or below 135% of Federal Poverty Guideline. Please check the box below that applies to your household and attach the supporting documentation described below: (**Income based on 2017 Federal Poverty Guidelines)** |
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| Please check | # household members | Household Income(at or below) |
|   | 1 | $16,281 |
|  | 2 | $21,924 |
|  | 3 | $27,567 |
|  | 4 | $33,210 |
|  | 5 | $38,853 |
|  | 6 | $44,496 |
|  | 7 | $50,139 |
|  | 8 | $55,782 |
|  | No. \_\_\_ | \* Add $5,643 each additional person |

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| Please attach one of the documents below if you did not check any boxes in #1. |
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|  Previous Year State/Federal or Tribal Tax Return |
|  Veterans Administration statement of benefits |
|  Social Security Administration statement of benefits |
|  Retirement/pension statement of benefits |
|  Unemployment/Workers Compensation statement of benefits |
|  Current year-to-date earnings statement from an employer or 3 consecutive months of pay stubs |
|  Federal or tribal notice of participation in Bureau of Indian Affairs General Assistance |
|  Divorce decree or child support wage assignment statement |

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**Benefit Qualifying Person Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_ SS# last 4: \_\_\_\_\_\_\_**

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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|  | **Initials Required: I hereby certify under penalty of perjury that:** |
|  | 1. I (or my dependent or other member of my household) currently receive(s) benefits from the federal program(s) identified or my annual household income is at or below 135 percent of the Federal Poverty Guidelines (or the amount that applies to my state as indicated in the chart on page 1). \_\_\_\_\_\_\_\_\_\_\_ |
|  | 2. I understand that I must notify my service provider within 30 days (1) of my new address if I move or (2) if for any reason I no longer satisfy the criteria for receiving Lifeline benefits including: (a) I, or the eligible person in my household, no longer meet the program or income eligibility criteria or (b) my household receives more than one Lifeline discounted service (i.e., more than one Lifeline telephone service).\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | 3. I acknowledge that my household can only receive one Lifeline Program benefit and, to the best of my knowledge, my household is not receiving more than one Lifeline Program benefit (i.e., only receiving a benefit for one home phone service or for one mobile phone service, but not both). \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | 4. I agree that my service provider may transmit to the Administrator of the National Lifeline Accountability Database my full name, my full residential address, my date of birth, the last four digits of my Social Security Number, the telephone number that is associated with the Lifeline Program benefit, the date on which the Lifeline Program service began, the date on which the Lifeline Program benefit ended, the amount of support sought by my service provider, and the means through which I qualify for the Lifeline Program benefit. I understand that transmission of this information is required to ensure the proper administration of the Lifeline Program. I also understand that if I refuse to have this information transmitted to the Administrator, I will be denied Lifeline Program benefits.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | 5. All of my responses and acknowledgements provided on this recertification form are true and correct to the best of my knowledge.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | 6. I acknowledge that willingly making false statements or providing false or fraudulent information to obtain Lifeline Program benefits is punishable by law and can result in fines, imprisonment, de-enrollment, or being barred from the program.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | 7. I may be required to recertify my continued eligibility at any time and failure to recertify my eligibility for the Lifeline Program will result in my removal from the Lifeline Program and termination of my Lifeline benefit.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature Date