

# National Grid Discount Rate Application

Significant savings are available to eligible gas 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 Number:

     -     

Social Security Number:

   -   -    

Name \_\_\_\_\_ Telephone Number \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Eligibility Criteria for the discount rate:

- ▶ You are a residential customer (primary dwelling only),
- ▶ Your gas bill is in your name,
- ▶ And either you are eligible for the low-income home energy assistance program (LIHEAP), or its successor program, for which eligibility does not exceed 200% of the federal poverty level based on a household's gross income. In a program year in which maximum eligibility for LIHEAP exceeds 200% of the federal poverty level, a household that is income eligible under LIHEAP shall be eligible for the low-income gas discount.
- ▶ Or You are currently receiving benefits under a means-tested program.

**I receive benefits from the following program(s):**

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

\*Please provide proof of benefits. Acceptable forms of proof include a program I.D. card or 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 I am income eligible.

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

If you have any questions about the program, please contact us at the Customer Assistance telephone number on your bill.

Please mail this application and supporting eligibility documents to:

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

Or fax application and document to: 866-713-0714

This is an important notice. Please have it translated.

Este é um aviso importante. Queira mandá-lo traduzir.  
Este es un aviso importante. Sírvase mandarlo traducir.  
Avis important. Veuillez traduire immédiatement.

Questa è un'informazione importante,  
si prega di tradurla.

ĐÂY LÀ MỘT BẢN THÔNG CÁO QUAN TRỌNG  
XIN VUI LÒNG CHO DỊCH LẠI THÔNG CÁO ẤY

Это очень важное сообщение.  
Пожалуйста, попросите чтоб  
вам его перевели.

# National Grid Discount Rate Application

Significant savings are available to eligible electric 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 Number:

-

Social Security Number:

-   -

Name \_\_\_\_\_ Telephone Number \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Eligibility Criteria for the discount rate:

- ▶ You are a residential customer (primary dwelling only),
- ▶ Your electric bill is in your name,
- ▶ And either you are eligible for the low-income home energy assistance program (LIHEAP), or its successor program, for which eligibility does not exceed 200% of the federal poverty level based on a household's gross income. In a program year in which maximum eligibility for LIHEAP exceeds 200% of the federal poverty level, a household that is income eligible under LIHEAP shall be eligible for the low-income electric discount,
- ▶ Or you are currently receiving benefits under a means-tested program.

**I receive benefits from the following program(s):**

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

\*Please provide proof of benefits. Acceptable forms of proof include a program I.D. card or 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 I am income eligible.

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

**Please mail or fax, your eligibility documentation:**

National Grid Accounts Processing, Massachusetts Discount Rate, Post Office Box 960, Northborough, MA 01532-9906  
 Fax: 877-388-9077

If you have any additional questions, please call our Customer Service Department at 1-800-322-3223, available Monday-Friday, 7:00am-7:00pm; Saturday, 7:00am-5:00pm; or for your convenience, visit us at [www.nationalgridus.com](http://www.nationalgridus.com).

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 XIN VUI LÒNG CHO DỊCH LẠI THÔNG CÁO ẤY

Это очень важное сообщение  
 Пожалуйста, попросите чтобы  
 вам его перевели.

**EVERSOURCE  
DISCOUNT RATE APPLICATION**

If you are currently eligible for fuel assistance, or are receiving one of the benefits listed below, you may also be eligible for **Eversource's Discount Rate**. Please note, eligibility for the Discount Rate isn't limited to these programs, as other means-tested public benefits are also eligible. Please call (800-566-2080) or email us if you have any questions.

Your household income must also meet eligibility requirements, and your Eversource bill must be in your name. If you think you may qualify, please fill in this form, then print this web page, sign it, and either fax it to 781-441-8512 or mail it to:

Eversource  
Customer Service  
247 Station Drive NW200  
Westwood, MA 02090-9909

Electric Account #:

Gas Account #:

Name (as shown on bill):

Address:

Suite/Apt:

City:

State:

Zip:

Daytime Phone #:

Social Security #:

I receive a benefit under the following programs (please check all that apply):

Programs:

- Supplemental Security Income (SSI)
- Transitional Aid to Families with Dependent Children (TAFDC)\*
- Emergency Aid to Elderly, Disabled and Children (EAEDC)
- Food Stamps\*
- Refugee Resettlement Benefits\*
- MassHealth Basic and Standard
- Low Income Home Energy Assistance (LIHEAP)
- Head Start\*
- Free and Reduced School Lunch or Breakfast Program\*

**EVERSOURCE  
DISCOUNT RATE APPLICATION**

- Mass. Veterans Benefits (GLC. 115)\*
- Dependency and Indemnity Compensation (DIC) for Surviving Spouse or Parents of Veterans (Dependency Indemnity Compensation letter required)
- Improved Veterans Disability Pension (Non-Service Connected Disability letter required)
- WIC\*
- Commonwealth Care Plan, Types 1, 2 or 2A\*
- Health Safety Net Plan - Primary or Secondary (not partial)\*

**\*Eligibility letter required. Please include a copy.**

I certify each of the following to be true. I receive assistance benefits under program(s) checked above. I receive an Eversource bill in my name. I authorize the agency responsible for benefit(s) being received to release information on this application to Eversource. I authorize the administrator of the program checked above to notify the company in the event that my benefits are terminated. I also understand that I am required to notify Eversource if my benefits end.

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

*This program is offered by Eversource. Once your eligibility is verified, a "residential assistance" rate code will appear on your bill. You will be eligible to receive this discount for one year, and must renew your eligibility annually.*

*If Eversource does not receive proper documentation within 60 days, you will be removed from the Discount Rate and re-billed at the regular rate starting from the date you originally applied for the discount.*

Upon completion, please print this web page, sign and either mail or fax this form to the phone number or address above.

**EVERSOURCE  
CERTIFICATION OF SERIOUS ILLNESS**  
Telephone (1-800-592-2000) Fax (781-441-3686)

Our customer has applied to Eversource (Company) for protection of their gas service from termination because they or someone in their household is suffering from a serious illness.

In compliance with M.G.L.c.164 124A, the Company may not terminate gas service to this customer provided you, as a registered physician, physician's assistant, nurse practitioner or local Board of Health official, certify in writing to the Company that our customer or someone living in the household is suffering from a serious illness. Your certification of serious illness shall be conclusive evidence of the existence of the serious illness claimed unless, after review, the Massachusetts Department of Public Utilities determines otherwise.

The certificate of serious illness shall be renewed quarterly unless the illness is chronic. A certificate of chronic serious illness shall be renewed every six months.

**PHYSICIAN'S CERTIFICATION**

I, \_\_\_\_\_ certify that my patient  
(Print Physician's Name)

\_\_\_\_\_  
(Print Patient's Name)

of \_\_\_\_\_  
(Patient's Street Address) (Apartment Number) (City and State)

is suffering from a serious illness or chronic serious illness. The nature of the illness is

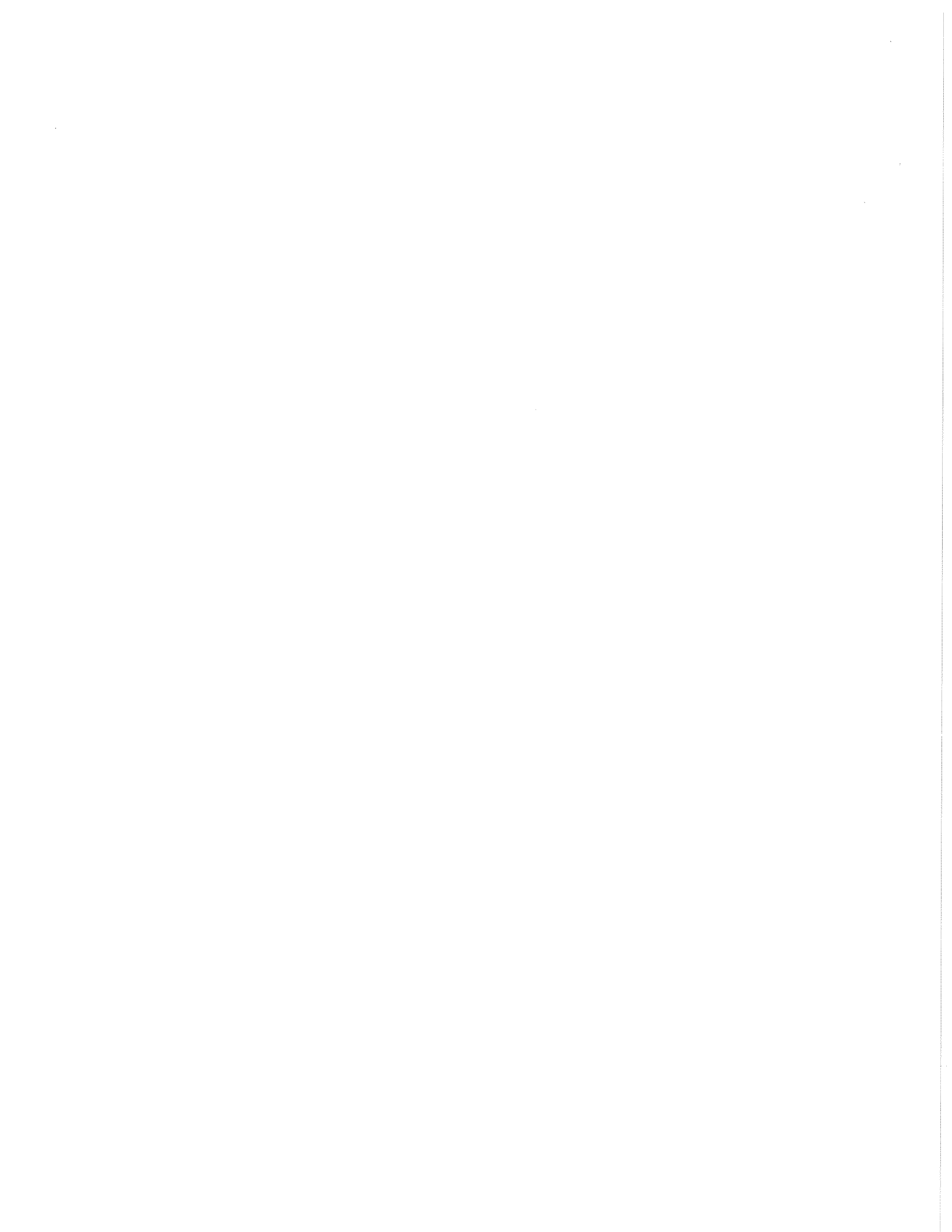
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
(Physician's Signature) (Date)

\_\_\_\_\_  
(Physician's Street Address) (City and State)

\_\_\_\_\_  
(Area Code) (Telephone Number) (Area Code) (Fax Number)

Please return within seven days of receipt to: Eversource Protected Accounts NW200, One NSTAR Way, Westwood, MA 02090-9230.



**Eversource Elderly Shut-off Protection - With Minor Child or Children (Financial Hardship Information Required)**

**Form C** - All adults in my home are age 65 or older, one or more minor children reside in the home and there is a financial hardship.

Pleas list the name and date of birth of all household members:

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Financial Hardship Information**

Name: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Number of People living in Household: \_\_\_\_\_

Total income for all household members before taxes (should include sources such as Wages, Social Security, TAFDC, Child Support, etc.):

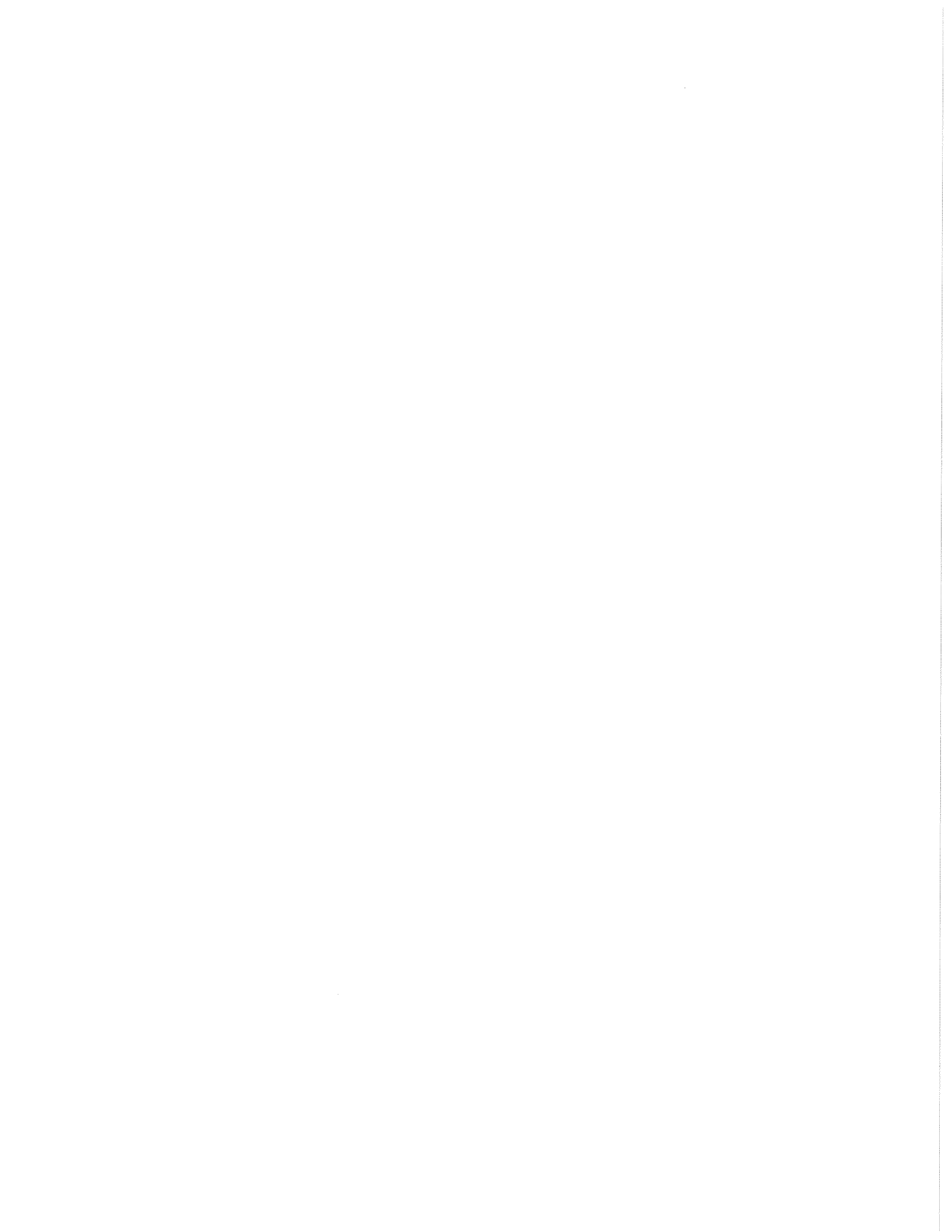
Total Income per Month: \_\_\_\_\_ Total Income Per Year: \_\_\_\_\_

I certify that the above information is complete and true to the best of my knowledge:

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

**For any of the protections, please remember to enclose a photo copy of your driver's license or other proof of age for all adults in the household.**

**PLEASE NOTE:** Customers who receive certain public benefits such as SSI, Food Stamps, Fuel Assistance, qualifying MassHealth coverage, and others may be eligible for the Eversource Discount Rate. If you are not already on the discount rate and think you may qualify, please contact Eversource at 800-592-2000 to request an application. An application is also on Eversource.com





## EVERSOURCE OVER 65 FORM

### Form A - Everyone in my home is 65 or older.

Please list the name and date of birth of all household members.

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City & Zip Code: \_\_\_\_\_

Eversource Account #: \_\_\_\_\_

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

### Part B (Optional) - Double Notice

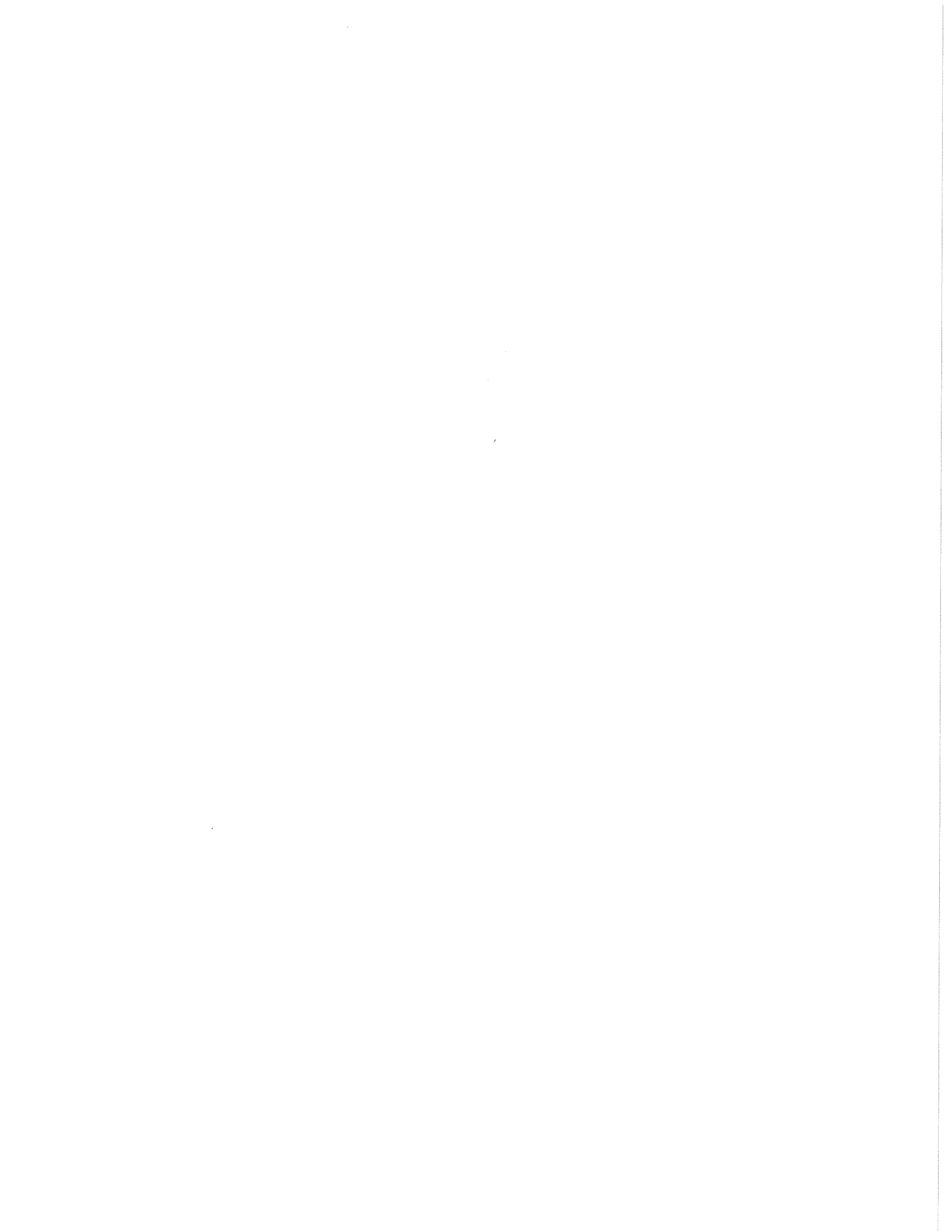
Yes, please send notices from Eversource about my overdue bills to the person below. I understand this person will not be responsible to pay for my bill, but will receive reminder notices.

Name of Notice Recipient: \_\_\_\_\_

Address: \_\_\_\_\_

City, State & Zip Code: \_\_\_\_\_

Notice Recipient Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## BASIC RULES/GETTING SERVICE

- Termination rules:
  - Only M-Th, 8-4; no Sat., Sun., holiday, or day before holiday
  - No term. if dispute pending
  - Init. Bill, 2<sup>nd</sup> notice (day 27+); final notice (day 45+)
  - Final must give 72 hrs. notice; good 14 days

## ELIGIBILITY FOR KEY PROTECTIONS AGAINST TERMINATION

<u>Protection</u>	<u>Requirements</u>
Elderly	<ul style="list-style-type: none"> <li>• <u>All</u> adult household members must be 65 or older.</li> <li>• Household must notify company.</li> <li>• <u>No</u> proof of financial hardship required; company must get individual permission of DPU to terminate.</li> <li>• <u>IF</u> there is a financial hardship, termination absolutely prohibited.</li> </ul>
Serious Illness	<ul style="list-style-type: none"> <li>• Must show that <u>someone</u> (customer or family member) is seriously ill, by submitting <u>letter from doctor/nurse practitioner or physician's assistant</u>.</li> <li>• Must demonstrate financial hardship.</li> <li>• Serious illness letter must be renewed every 90 days (or every 180 days for a "chronic" illness).</li> </ul>
Winter Moratorium	<ul style="list-style-type: none"> <li>• Applies to gas (if used to heat) or electricity (if used to operate furnace, boiler, thermostats, or heating controls).</li> <li>• Runs from November 15<sup>th</sup> – March 15<sup>th</sup> (often extended).</li> <li>• Must demonstrate financial hardship.</li> </ul>
Infant	<ul style="list-style-type: none"> <li>• An infant under the age of 12 months must be living in the household.</li> <li>• Must submit birth certificate, baptismal certificate, or other reasonable proof of age.</li> <li>• Must demonstrate financial hardship.</li> </ul>