

Discount Rate Application -

Western Eastern Massachusetts



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 is not limited to only these programs, as other means-tested public benefits are also eligible. If you have any questions about the application, please call us at 877-659-6326, Monday through Friday, 8 a.m. to 6 p.m.

Yes, I would like to apply for Eversource's Discount Rate. I authorize the agency(s) providing my benefits to release information to Eversource for enrollment and annual recertification for the Discount Rate and to notify Eversource if my benefits are discontinued. I also understand that I am required to notify Eversource if my benefits are discontinued.

Eversource Account Number:

--	--	--	--	--	--	--	--	--	--	--

First Name:

Last Name:

Middle Initial:

Address:

City:

ZIP Code:

Email Address:

Telephone Number: - -

Eligibility Criteria

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

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

- | | |
|--|--|
| <input type="checkbox"/> Low Income Home Energy Assistance Program (LIHEAP/Fuel Assistance)* | <input type="checkbox"/> Supplemental Nutrition Assistance Program (SNAP/Food Stamps) * |
| <input type="checkbox"/> Supplemental Security Income (SSI) | <input type="checkbox"/> Veterans Dependency & Indemnity Comp (DIC) Surviving Parent or Spouse * |
| <input type="checkbox"/> MassHealth – Basic or Standard* | <input type="checkbox"/> School Breakfast/Lunch Program * |
| <input type="checkbox"/> Emergency Assistance for the Elderly, Disabled & Children (EAEDC) * | <input type="checkbox"/> Veterans Non-Service Disability Pension * |
| <input type="checkbox"/> Public or Subsidized Housing * | <input type="checkbox"/> Commonwealth Care Plan Types 1, 2, or 3A * |
| <input type="checkbox"/> Transitional Aid to Families with Dependent Children (TAFDC) * | <input type="checkbox"/> Health Safety Net Plan – Primary or Secondary (Not Partial) * |
| <input type="checkbox"/> Head Start * | <input type="checkbox"/> Women, Infants & Children (WIC) Nutritional Program* |
| <input type="checkbox"/> Veterans' Service Benefits (Chapter 115) * | |

* Please provide proof of benefits, for example a copy of the certifying agency's acceptance letter.

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

Signature:

Date::

After completing the application, please mail it and any copies of your eligibility documentation to:

Attn: Billing
Eversource
P.O. Box 330, Manchester, NH 03105
You can also fax the information to:
800-265-6708