

**Concord Light**  
1175 Elm Street  
P.O. Box 1029  
Concord, MA 01742

*If you have  
questions, please  
call us at  
978-318-3101*

## ***Residential Assistance Rate Application***

To be eligible for this rate:

- Your household income must not exceed 200% of the Federal poverty level;
- You are a residential customer (primary dwelling only);
- Your electric bill is in your name; AND
- You are currently receiving benefits under one of the following programs: EAEDC, Food Stamps, Head Start, Mass Commission for the Blind Benefits, National School Lunch Program, Public Housing, School Breakfast Program, Supplemental Security Income, TAFDC, Veterans Chapter 115 Benefits, Veterans DIC Surviving Parent, Veterans Non-Service Pension, Fuel Assistance (includes receipt of benefits or verification of eligibility for the program)

**This electric rate will not affect the benefits you currently receive and will reduce your electric bill.**

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*YES! I would like to apply for the Residential Assistance Rate.*

I authorize the agency providing me benefits to:

1. Release information to Concord Light for enrollment and annual recertification in the discounted electric rate.
2. Notify Concord Light if my benefits are discontinued.

I understand that I am also required to notify Concord Light if my benefits are discontinued. Residential Assistance Rate eligibility must be renewed each year by completing an application provided by Concord Light.

\_\_\_\_\_  
LAST NAME (PLEASE PRINT)

\_\_\_\_\_  
FIRST NAME

\_\_\_\_\_  
ADDRESS

\_\_\_\_\_  
CITY

\_\_\_\_\_  
STATE

\_\_\_\_\_  
ZIP

\_\_\_\_\_  
TELEPHONE NUMBER

\_\_\_\_\_  
SOCIAL SECURITY NUMBER

\_\_\_\_\_  
CMLP ACCOUNT NUMBER

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

I am currently receiving benefits under the following programs and have attached written verification (please check):

- |   |   |  |                                      |
|---|---|--|--------------------------------------|
| <input type="checkbox"/> Supplemental<br>Income           | <input type="checkbox"/> TAFDC                            | <input type="checkbox"/> EAEDC                                     | <input type="checkbox"/> Food Stamps |
| <input type="checkbox"/> Public Housing                   | <input type="checkbox"/> Head Start                       | <input type="checkbox"/> Veterans Non-<br>Service Pension          |                                      |
| <input type="checkbox"/> Veterans Chapter<br>115 Benefits | <input type="checkbox"/> Veterans DIC<br>Surviving Parent | <input type="checkbox"/> Fuel Assistance<br>Application # _____    |                                      |
| <input type="checkbox"/> National School<br>Lunch Program | <input type="checkbox"/> School Breakfast<br>Program      | <input type="checkbox"/> Mass Commission for the<br>Blind Benefits |                                      |

A recent proof of benefits, along with your application, is required for the above programs.

\_\_\_\_\_  
AGENCY NAME (MUST BE PROVIDED FOR PUBLIC AND/OR SUBSIDIZED HOUSING)

\_\_\_\_\_  
TELEPHONE