2025 Low Income Disabled Discount Application

Qualified Benton PUD customers may receive a 10%, 15% or 25% monthly discount, or the equivalent of the daily system charge (whichever is greater), if they or member of the household has a qualifying disability and their total annual household income is at or below 225% of the Federal Poverty Guidelines. Only one discount per customer is allowed and will be applied to the residence where the disabled individual resides.

The original application must be returned to Benton PUD for processing. Once the application is received by Benton PUD, the discount will go into effect on the first day of the customer's next billing period. An application, disability verification and income verification are required every three years, or upon request of Benton PUD, to receive the monthly discount. If your income declines within the three-year period, please contact us to determine if you are eligible for a higher discount.

The customer or household member must provide certain medical information to Benton PUD in order to qualify for the low income discount. The medical information that is provided to Benton PUD to support the application will be used solely by Benton PUD to determine the initial and continuing eligibility for, and in compliance with, Benton PUD's Low Income Disabled Discount, and will not be disclosed to third parties. The customer must notify Benton PUD immediately if they or the household member no longer qualifies for the discount due to a change in circumstances, such as 1) they or the household member no longer have a qualifying disability; or 2) they or the household member no longer meet the income requirements for this discount.

STEP 1: INCOME ELIGIBILITY

Low Income Qualification

TOTAL ANNUAL HOUSEHOLD INCOME, from all sources, must be 225% or less of the Federally Established Poverty Guidelines. See Step 4 for income verification requirements.

	10% Discount	***15% Discount***	***25% Discount***
Size of family	**Up to 225% of Poverty Level**	**Up to 200% of Poverty Level**	**Up to 150% of Poverty Level**
1	$35,213	$31,300	$23,475
2	$47,588	$42,300	$31,725
3	$59,963	$53,300	$39,975
4	$72,338	$64,300	$48,225
5	$84,713	$75,300	$56,475
6	$97,088	$86,300	$64,725
7	$109,463	$97,300	$72,975
8	$121,838	$108,300	$81,225

Exp. Date

Name

STEP 2: CUSTOMER AND APPLICANT INFORMATION

Customer Name ____

Customer Address ____________________ City __________ State, Zip ________

Benton PUD Account No. ____________________Phone No. ______________

Name of household member (referred to as “Applicant”) with disability who resides with

Customer ____

Relationship to Customer ______________________________________

STEP 3: DISABILITY VERIFICATION – *CHOOSE ONE OF THREE OPTIONS*

This verification applies to the Applicant listed in Step 2

Option 1: ☐ Proof of a valid Washington State Disabled Parking Permit
Permit Number ____________________ Expiration Date ______________

Option 2: ☐ Verification of receipt of Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI) by CAC or governmental employee:
I hereby certify that I am an employee of CAC (or other named governmental entity) and that I have been provided proof of the Applicant’s disability through SSDI or SSI.
Full Name of Employee (please print) ______________________________
Employee Signature ______________________________________

Option 3: ☐ Certification of Disability by Physician or Mental Health Professional – CHOOSE ONE

☐ ***Physician’s Certification of Disability***

The intent of the Low Income Disabled Discount program is to extend a special electric billing discount to low income persons with disabilities that substantially impair mobility or the ability to maintain gainful employment.

I hereby certify that I am a licensed physician and that the above named Applicant has a disability as defined under Qualified Disabilities on this application that substantially impairs the Applicant’s mobility or ability to maintain gainful employment.

Full Name of Physician (please print) ________________________
Physician’s Signature ______________________________
Address ______________ City __________State ______Zip ________
License No. ____________ Phone No. __________Date __________

☐ ***Mental or Developmental Health Professional’s Certification of Disability***

The intent of the Low Income Disabled Discount program is to extend a special electric billing discount to low income persons with disabilities that substantially impair mobility or the ability to maintain gainful employment.

I hereby certify that I am a Mental or Developmental Health Professional or licensed Social Worker authorized to certify that the above named Applicant has a disability as defined under Qualified Disabilities on this application that substantially impairs the Applicant's mobility or ability to maintain gainful employment.

Full Name of Professional (please print) ______________________________
Professional's Signature ______________________________
Address ____________________ City ____________State ________Zip _________
License No. __________________ Phone No. ____________Date ______________
Firm, Agency or Program Name ______________________________

STEP 4: INCOME VERIFICATION

To have the household income verified, please go to Community Action Connections (CAC) located in Pasco at 720 W. Court Street or in Prosser at 424 6th Street, Suite 2. They can be reached at 509-545-4065 in Pasco or 509-786-3379 in Prosser. Income verification may also be provided by an authorized government agency.

The following information is required to verify income:
VERIFICATION FOR ALL PERSONS BEING INCLUDED IN THE TOTAL HOUSEHOLD INCOME MUST BE PROVIDED TO CAC

- ***One of the following***: A copy of a bank statement(s) showing a direct deposit of a Social Security or pension benefit(s) or other form of income, a benefit or award letter(s), or a copy of a Social Security check(s); **AND**
- ***One of the following***: A copy of a Social Security card(s) or document with Social Security number(s) and name(s) included; **AND**
- ***One of the following***: Proof of Date of Birth (Birth Certificate or WA ID); **AND**
- ***Two of the following***: Proof of address (Driver's License, WA ID or utility bill)

To be filled out by CAC or authorized agency:
Number of persons in household (including Applicant) ______________________________
Total Annual Household Income $ ______________________________

We have verified that the total annual household income, based on family size, is the amount listed above, which is 225% or less of the Federally Established Poverty Guidelines.
Agency Name ____________________________ Phone No. ____________Date ______________
Agency Address _________________________City ______________State _________Zip ________

I hereby certify that the foregoing information is correct and I am an authorized signatory of the agency.
By ____Title _____________________Date ________

STEP 5: AGREEMENT AND SIGNATURES

I hereby certify that the information on this application is correct. I agree to notify Benton PUD immediately if my account no longer qualifies for a discount under this program.

Customer's Signature ____ Date ________________

I hereby certify that the information on this application is correct. I agree to notify Benton PUD immediately if my account no longer qualifies for a discount under this program.

Applicant's Signature* _______________________________________ Date ________________
*If the Applicant is a minor child, incapacitated, or otherwise unable to sign this document, a parent or legal guardian of the Applicant must sign.

The original application must be returned to Benton PUD for processing. Thank you.

Qualified Disabilities

The Applicant:

- Cannot walk two hundred feet without stopping to rest;
- Is severely limited in ability to walk due to arthritic, neurological, or orthopedic condition;
- Has such a severe disability that the person cannot walk without the use of or assistance from a brace, cane, another person, prosthetic device, wheelchair, or other assistive device;
- Uses portable oxygen;
- Is restricted by lung disease to an extent that forced expiratory respiratory volume, when measured by spirometry, is less than one liter per second or the arterial oxygen tension is less than sixty mm/hg on room air at rest;
- Impairment by cardiovascular disease or cardiac condition to the extent that the person's functional limitations are classified as class III or IV under standards accepted by the American heart association;
- Has a disability resulting from an acute sensitivity to automobile emissions that substantially limits the person's ability to walk or maintain gainful employment.
- Has limited mobility and has no vision or whose vision with corrective lenses is so limited that the person requires alternative methods or skills to do efficiently those things that are ordinarily done with sight by persons with normal vision;
- Has an eye condition of a progressive nature that may lead to blindness; or
- Is restricted by a form of porphyria to the extent that the applicant would significantly benefit from a decrease in exposure to light.
- Has a disability (physical or mental) that substantially impairs mobility or the ability to maintain gainful employment.

BPUD use only:
☐ 10% discount ☐ 15% discount ☐ 25% discount
Entered by ______________________________________ Date _______________