# LIFELINE & LINK-UP
# TELEPHONE ASSISTANCE APPLICATION
## 1401 Main Street Suite 900
## Columbia, SC 29201

**Name:** _____
First MI Last

**Street Address:** _____
Apt #

**City:** _____ **State**: _____ **Zip:** _____

**Phone Company Name:** _____ **Your Phone Number:** (___)____-_____

**Please list the card or account number(s) for the public assistance program(s) you receiving (check all that apply):**

- ☐ Medicaid ID # _____
- ☐ Food Stamps Card # _____
- ☐ Family Independence (TANF) Account/Client# _____

To receive Lifeline and/or Link-up assistance I authorize the Office of Regulatory Staff (ORS) to release my information to the telephone company listed above. I understand the agency will release my name and telephone number, but only if I meet the necessary qualifications. I authorize the Department of Health and Human Services to release information about my Medicaid eligibility to the telephone company. I understand the agency will release my name, Social Security Number and telephone number, but only if I receive Medicaid. The consent remains in effect as long as I meet the eligibility requirements or until I no longer want Lifeline.

I certify that the telephone number listed above is in my name. I understand that to qualify for the credit, the telephone service must be in my name, and I must receive the telephone bill. I understand that this form is not an application for telephone service.

Signature of Applicant: _____ Date: _____

**OFFICIAL USE ONLY**

I certify that the applicant participates in the above listed public assistance program(s):

Signature: _____ Date: _____