ATLAS TELEPHONE COMPANY
LIFELINE/LINKUP AMERICA
AUTHORIZATION AND CERTIFICATION FORM

Federal law requires that you complete and sign this certification form in order to be enrolled and/or continue to be enrolled in the federal Lifeline and Link Up America programs. This authorization and certification is only for the purpose of enrolling you in these programs and will not be used for any other purpose.

Lifeline is a federal benefit and willfully making false statements to obtain the benefit can result in fines, imprisonment, de-enrollment or being barred from the program. Only one Lifeline service is available per household. A household is defined, for purposes of the Lifeline program, as any individual or group of individuals who live together at the same address and share income and expenses. A household is not permitted to receive Lifeline benefits from multiple providers. Violation of the one-per-household limitation constitutes a violation of FCC rules and will result in the subscriber's de-enrollment from the program.

Lifeline service is a non-transferable benefit, and a Lifeline subscriber is prohibited from transferring their Lifeline service to any other person.

FAILURE TO COMPLETE THIS CERTIFICATION FORM AND RETURN IT TO ATLAS TELEPHONE COMPANY, INC WITHIN 30 DAYS WILL RESULT IN YOUR DE-ENROLLMENT FROM THE LIFELINE BENEFIT PROGRAM AND WILL CAUSE YOU TO BE SOLELY RESPONSIBILE FOR MONTHLY CHARGES FOR YOUR SERVICE.

A. CUSTOMER/APPLICANT INFORMATION (Please print)

Applicant's Full Name _____

Applicant Telephone Number _____

Applicant's Service Address (No PO Boxes):

Street: _____ City_____ State_____ Zip Code_____

This address is my □ Permanent or □ Temporary address. (check one)

Do you live at an address at which there are multiple households (for example, a nursing home or group home)? □ Yes □ No (If yes, you must complete a supplemental form to determine your eligibility)

Applicant's Billing Address, if different from service address (may include a post office box):

Street Address: _____ City_____ State_____ Zip Code_____

Applicant's Date of Birth_____

Last four digits of Applicant's Social Security Number or Tribal identification number: _____

B. PROGRAM-BASED ELIGIBILITY (CHECK ALL THAT APPLY)

I hereby certify that I qualify for and receive benefits from at least one of the following programs

_____ Medicaid (*SoonerCare)*
_____ Supplemental Nutrition Assistance Program (SNAP)
_____ Supplemental Security Income (SSI)
_____ Federal Public Housing Assistance (FPHA)
_____ Veterans or Survivors Pension Benefit
_____ Bureau of Indian Affairs General Assistance
_____ Tribally administered Temporary Assistance for Needy Families (TANF)
_____ Head Start Programs (only applicant or customer who satisfies the income qualifying eligibility provision)

Recipients Full Name_____ **SS#**_____ DOB_____

_____ Food Distribution Program on Indian Reservations ("FDPIR")