Affordable Connectivity Program Fact Sheet

Please fill each line with the same information you used on to verify your eligibility on the National Verifier website.

Full Name:

Address:

City, State, Zip Code:

Telephone Number: Date of Birth:

Last 4 of SSN: Tribal ID:

ACP Application ID:

If another individual is the Benefit Qualifying Person (BQP), please include their information below.

BQP's Full Name:

BQP's Address:

BQP's City, State, Zip Code:

BQP's Date of Birth:

BQP's Last 4 of SSN: BQP's Tribal ID:

Qualified Programs:

- Medicaid
- SNAP
- SSI
- Federal Public Housing Assistance
- Low-income Home Energy Assistance Program (LIHEAP)
- TANF
- National School Lunch Program's Free Lunch Program
- Bureau of Indian Affairs General Assistance
- Tribal TANF
- Food Distribution Program on Indian Reservations (FDPIR)
- Head Start
- State Assistance Programs
- Eligibility based on Income
- Program Eligibility approved by State Administrator
- Veterans Pension or Survivors Pension
- State Eligibility Waiver

I understand this is a U.S. government program that reduces my internet bill.

I understand this program is limited to one per household. A household is defined as anyone living at the same address who share income and household expenses.

I understand this program is non-transferable to any other individual or household.

I understand I may choose to participate in the Affordable Connectivity Program (ACP) from any service provider.

I understand I may transfer the Affordable Connectivity Program benefit to another provider at any time during this program.

I allow Starwire Technologies, LLC to transmit my information to the National Lifeline Accountability Database to enroll into the Affordable Connectivity Program.

I understand that I have to give Starwire Technologies, LLC 30 day notice if I no longer qualify for the ACP benefit, including:

> I, or the person in my household that qualifies, no longer qualify through a government program or income no longer qualifies.

Either I or someone in my household receives an additional ACP benefit.

I agree that all of the information I provide on this form may be collected, used, shared, and retained for the purposes of applying for and/or receiving the ACP benefit. I understand that if this information is not provided to the Program Administrator, I will not be able to get ACP benefits. If the laws of my state require it, I agree that the state may share information about my benefits for a qualifying program with the ACP Administrator. The information shared by the state will be used only to help find out if I can get an ACP benefit.

All the answers and agreements that I provided on this form are true and correct to the best of my knowledge.

I know that willingly giving false or fraudulent information to get ACP benefits is punishable by law and can result in fines, jail time, de-enrollment, or being barred from the program.

Signed: _____

Print Name: _____