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September 10, 2020

*Submitted online via EFIS*
Missouri Public service Commission
Attention: Data Center
200 Madison Street, Suite 100
Jefferson City, MO 63101

**Re: In the Matter of Staff's Review of Information Regarding Section 54.314 ETC Certification (File No. BUSF-2021-0008)**

Dear Sir or Madam:

At the request of **Oregon Farmers Mutual Telephone Company, Study Area 421935**, I am submitting the current version of the Company's Disable Program application. The attached version properly shows the $24.00 discount, which has been in place for all of 2020, and replaces an older version that showed an inaccurate discount level.

The Company has, at all time, provided its Disabled Program subscribers the correct discount amount.

Please refer to the enclosed version of the Disabled Program application as the Attachment A to documents submitted for placement in Commission Docket Number TO-2020-0352, supporting its annual ETC designation, to be place in MO PSC file BUSF-2021-0008.

Please direct any questions regarding this submission, or requests for additional detail, to me at rabrams@bkd.com or to 608-410-4768.

Respectfully,

BKD, LLP

Robert R. Abrams
Senior Managing Consultant

BKD LLP
CPAs & Advisors

Enclosure

cc: Adam Dixon, Oregon Farmers Mutual Telephone Company
Charles Custer, Oregon Farmers Mutual Telephone Company

# Oregon Farmers Telephone Company
# Missouri Application for the Disabled Program

Consumers meeting certain eligibility criteria are able to receive a $24.00 monthly discount for residential voice telephony service through the Disabled program. To apply, complete this form and submit proof of eligibility.

## **Disabled program eligibility criteria (**Check all programs that you or someone in your household currently participates in)**:**

____ Veteran Administration Disability Benefits
____ State Blind Pension
____ State Aid to Blind Persons
____ State Supplemental Disability Assistance
____ Federal Social Security Disability

Applicant's Full Name: _____Birth Date: _____

Last 4 Digits of Social Security #: _____ Customer Contact Telephone #: _____

Name on Voice Service Account (if different from Applicant): _____

Customer's Address (no P.O. boxes): Street_____

City/State/Zip _____

- **Is this address occupied by multiple households?** ___Yes ___No *If yes, an address with multiple households must respond to the following question(s) in the order indicated below:*

| Questions Solely for Multiple Households | Yes | No | Instruction |
|---|---|---|---|
| Do you live with another adult? | | | If no, you can apply for Disabled program. If yes, proceed to next question. |
| Do they get a benefit from the Lifeline or Disabled programs? | | | If no, you can apply for Disabled program. If yes, proceed to next question. |
| Do you share money (income or expenses) with them? | | | If no, you can apply for Disabled program. **If yes, you are ineligible for the Disabled program.** |

- **Is this address also the mailing address?** ___Yes ___No

If No, please provide mailing address:

_____

_____

**I understand the following obligations and provisions about the Disabled program:**

- The Disabled program is a government benefit program and willfully making false statements to obtain the benefit can result in fines, imprisonment, de-enrollment or being barred from the program.
- Only one benefit from either the Disabled or Lifeline programs is available per household.
- A household is defined 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 or Disabled program benefits from multiple providers.
- Violation of the one-per-household limitation constitutes a violation of rules and will result in the subscriber's de-enrollment from the program.
- The Disabled program is a non-transferable benefit and the subscriber may not transfer his or her benefit to any other person.

**I hereby certify under penalty of perjury that (please initial next to each statement):**

____ I meet the eligibility criteria for the Disabled program.

____ I will provide notification to my voice service provider within 30 days if for any reason I no longer satisfy the criteria for receiving Disabled benefits including if I or any member of my household receives a benefit from the Lifeline or Disabled programs.

____ My household will receive only one benefit from the Disabled or Lifeline programs and, to the best of my knowledge, my household is not already receiving a benefit from the Disabled or Lifeline programs.

____ I acknowledge I may be asked to verify my continued eligibility for Disabled benefits and failure to verify my continued eligibility will result in de-enrollment and the termination of Disabled benefits.

____ I consent to sharing my account information with the Missouri Public Service Commission who oversees and administers the Disabled program.

**The information supplied on this form is true and correct. I acknowledge providing false or fraudulent information to receive Disabled benefits is punishable by law.**

_____ _____

**Signature of Customer** **Date**

## Submit a completed signed form *and* proof of eligibility.

**Company Use Only:**

**I hereby attest the applicant presented acceptable proof of eligibility:**

_____ _____ _____

**Print name of company official** **Signature** **Date**

**Oregon Farmers Telephone Company**