



THE POWER IS YOURS
1411 W Clark Pasco, WA 99301

APPLICATION FOR LOW INCOME DISABLED DISCOUNT

Name: _____ Customer Number: _____
(PUD account must be in Applicant's Name)

Address: _____ Telephone Number: _____

Number of people Disabled parking Date
in household: _____ permit number: _____ issued: _____

ELIGIBILITY

1. A person who qualifies for special parking privileges under RCW 46.16.381(1) (a through h) or a blind person as defined in RCW 74.18.020(4).
2. A person whose total income, including that of his/her spouse or co-tenant, is at or below 125% of the federally established poverty level.
3. A person who is a customer with Franklin PUD and has service for electricity under Rate Schedule Number 1, Residential, in his/her name.
4. A disabled, handicapped, or incapacitated person as defined under RCW 71A.10.020(2) or 71.05.020(1), or any other existing state or federal program.
5. A physician's certificate is required if the customer does not have a disabled parking permit. (see reverse side)

LOW INCOME DISABLED INFORMATION

The Director shall grant special parking privileges to any person who meets one of the following criteria:

- (a) Loss of both lower limbs.
- (b) Loss of normal or full use of the lower limbs to sufficiently constitute a severe disability.
- (c) So severely disabled that the person cannot move without the aid of crutches or a wheelchair.
- (d) Loss of both hands.
- (e) Suffers from lung disease to such an extent that forced expiratory respiratory volume, when measured by spirometry, is less than one liter per second; or
- (f) Impairment by cardiovascular disease to the extent that the person's functional limitations are classified as Class III or IV under standards accepted by the American Heart Association.
- (g) "Blind" means a person who has no vision or whose vision with corrective lenses is so defective as to prevent the performance of ordinary activities for which eyesight is essential, or who has an eye condition of a progressive nature which may lead to blindness.
- (h) Hearing loss nor correctable and of such severity that gainful employment is prohibited.

Physician's Certificate

I hereby certify that I am a licensed physician and that the applicant has the permanent disability listed below:

Physician's Name: _____ Telephone Number: _____
Type of Physician: _____ License Number: _____
Address: _____ City, State: _____ Zip Code: _____
Type of Disability: _____
Signature: _____ Date: _____

Mental Health Professional's Certification

I hereby certify that I am a Mental Health Professional as defined in RCW 71.05.020(12) or a D.D.D. (DSHS) Social Worker authorized to certify that the applicant has a disability listed on the front of this application.

Name of Professional: _____ Telephone Number: _____
Agency or Program Name: _____
Address: _____ City, State: _____ Zip Code: _____
Signature: _____ Date: _____

Income Certification

We certify that the household income of the customer named above is 125% of the Federal Poverty Level.

Agency: _____ Date: _____
Address: _____ City, State: _____ Zip Code: _____
Name: _____ Title: _____
Signature: _____ Telephone Number _____

Affidavit: I swear under the penalties of either civil or criminal perjury that all of the above statements as marked are true and agree to provide the PUD with any required financial information upon request.

Applicant: _____ Date: _____
Witness: _____ Date: _____