Please mail to:
Pascoag Utility District
PO Box 107, Pascoag, RI 02859

Handicapped Protection Form

Please note: This is not a rate reduction.

I hereby state under oath that the following information is true and correct.

Customer Information:

(Please print.)

Account Holder Name: ____________________

Address: ____________________ City/Town: ____________________

Email Address: ____________________ Phone Number: ____________________

Electric Account Number: ____________________ Relation to Account Holder: ____________________

To qualify for handicapped protection you may either have the licensed physician complete this section of the Handicapped Protection Form OR submit proof of receiving Social Security Disability (SSD). The customer affidavit below MUST be completed to receive protection.

TO BE COMPLETED BY LICENSED PHYSICIAN:

Print Patient Name: ____________________

Print Impairment: ____________________

Print Licensed Physician's Name: ____________________

Physician's License Number: ____________________

Licensed Physician's Address: ____________________

Licensed Physician's Phone Number: ____________________

The Rhode Island Public Utilities Commission defines handicapped as a "physical or mental impairment which substantially limits one or more of such person's major life activities, and which would ordinarily prove a serious hindrance to obtaining employment. This impairment is material, rather than slight, relatively static as distinguished from definitely active or rapidly progressive, and relatively permanent in that it is seldom fully corrected by medical replacement, therapy or surgical means." I certify that the above mentioned individual, at the address listed above, is handicapped as defined above and all information provided regarding the patient's health is current and accurate.

Licensed Physician's Signature: ____________________ Date: ____________________

AFFIDAVIT TO BE COMPLETED BY CUSTOMER:

Residing permanently at this address is someone who has a physical or mental impairment which substantially limits one or more of such person's major life activities, and which would ordinarily prove a serious hindrance to obtaining employment. This impairment is material, rather than slight, relatively static as distinguished from definitely active or rapidly progressive, and relatively permanent in that it is seldom fully corrected by medical replacement, therapy or surgical means.

Customer Signature: ____________________ Date: ____________________

TO BE COMPLETED BY NOTARY PUBLIC:

The person whose signature appears above personally appeared before me and swore that the statements contained herein are true.

Notary Public Signature: ____________________ Date: ____________________

Notary Number: ____________________ Notary Expiration Date: ____________________

Pascoag Utility District requires this form to be submitted annually to recertify the existence of the handicap in order to maintain the protection.