

Line Extension Customer Assistance Program Application Form



Completed applications can be uploaded to the Department of Public Service via the [Telecom Contact Form](#),
 Emailed to: psd.telecom@vermont.gov or Mailed to: 112 State Street, Fl 3, Montpelier, Vermont 05620-2601

Cable/ISP estimates must be submitted with your application.

All sections are required unless noted. - Please allow two weeks for your application to be reviewed.

Line Extension/Service Drop Request

Application type: Line Extension with Service drop <input type="checkbox"/> Service Drop <input type="checkbox"/> <i>Line extensions are the Cable/ISP line along the roadways. (Up to \$3000 allowance.)</i> <i>Service drops connect individual home to the pole on your street, aerial or underground (Up to \$500 allowance)</i> The total allowance for the LECAP program does not exceed \$3000.	
Have you requested the line extension or service drop from a service provider? Yes <input type="checkbox"/> No <input type="checkbox"/> If "No" please request the estimate. A provider estimate must be submitted with this form.	
Service provider (Comcast, Charter, etc)	Service provider Contact information
Account number if applicable	
Provider estimated <u>consumer</u> cost of the line extension?	Provider estimated <u>total</u> cost of the line extension?
How much LECAP reimbursement are you requesting?	Have you/will you receive other government assistance for internet at this location?

To qualify, the line extension must be requested from a participating service provider in your area. The estimated consumer cost must be provided above. The consumer must request and submit a line extension estimate to the Department with the consumer costs identified. LECAP will provide up to \$3000 for line extension and service drop or \$500 for a service drop. Payments are made directly to the service provider on behalf of the applicant for the applicant's portion of a signed agreement. The remaining consumer cost over \$3000 will be the responsibility of the applicant. One application per address, will be approved. The full guidelines can be found at <https://publicservice.vermont.gov/content/vermont-covid-19-line-extension-customer-assistance-program>

Current Provider and Service

Do you currently have an internet connection Yes <input type="checkbox"/> No <input type="checkbox"/>	Current Provider
Current speed subscribed <i>Example 25/3 = 25Mbps download / 3Mbps upload</i>	
100/100 (fiber) <input type="checkbox"/> 25/3 <input type="checkbox"/> 10/1 <input type="checkbox"/> 4/1 <input type="checkbox"/> None <input type="checkbox"/> Other <input type="text"/>	

Note: PSD may verify the eligibility of the service location using its broadband availability data. For more details please see the LECAP Guidelines

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Who is applying

Applicant type	
Consumer <input type="checkbox"/> <i>Please complete the Consumer information section.</i>	On behalf of a Student/Patient/Resident <input type="checkbox"/> <i>Please provide your organization details.</i>
School, Healthcare, or Long Term Care representatives only	
Organization type	
School <input type="checkbox"/>	Healthcare provider <input type="checkbox"/>
	Long Term Care facility <input type="checkbox"/>
School/Health/LT Care Provider Organization:	EIN:
School/Health/LT Care Representative Name:	Phone number
	Email address(s)

Consumer information

Name	Phone number	Email address(s)
Mailing Address		
Physical Service Address <i>(Location for the line extension)</i>	Home <input type="checkbox"/>	Home/ Business <input type="checkbox"/>
	Long Term Care <input type="checkbox"/>	Other <input type="checkbox"/>
Street	City	State Zip

LECAP is intended for residential addresses. Business locations such as restaurants, retail shops are not eligible

Connectivity need(s) *(check all that apply)*

Distance Learning (PreK-12)	<input type="checkbox"/>	Telehealth/Telemedicine	<input type="checkbox"/>	Telework/Work from home	<input type="checkbox"/>
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Community/Neighborhood Project *(optional)*

*If your application is part of a community organized line extension please contact the Department by emailing psd.telecom@vermont.gov
Community/Neighborhood Projects still require one application per address.*

Organizer contact name	Organizer contact phone	Organizer contact email
Community/Neighborhood Name <i>(optional)</i>	Community/Neighborhood City	Community/Neighborhood street

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By signing this application, I certify that:

1. I have the authority to request payment from the State of Vermont. I am requesting payment of the total award amount for costs incurred in connection with section 601 of the Social Security Act, as added by section 5001 of the Coronavirus Aid, Relief, and Economic Security Act, Pub. L. No. 116-136, div. A, Title V (Mar. 27, 2020) ("section 601").

2. I understand that the State of Vermont will rely on this certification as a material representation in making this grant award.

3. As required by federal law, the proposed uses of the funds provided will be used only to cover those costs that-
 - a. are necessary expenditures incurred due to the public health emergency with respect to the Coronavirus Disease 2019 (COVID-19).
 - b. were not accounted for in the state budget most recently approved as of March 27, 2020.
 - c. were incurred during the period that begins on March 1, 2020 and ends on December 30, 2020.

4. To the best of my knowledge, as of the date that this Application is signed, neither Party nor Party's principals (officers, directors, owners, or partners) are presently debarred, suspended, proposed for debarment, declared ineligible or excluded from participation in Federal programs, or programs supported in whole or in part by Federal funds. Entities that are suspended and/or debarred will have received a notification letter from the Federal Government. Information on suspension and debarment can be found [here](#).

5. By submitting this application, I agree to repay this grant or any portion of this grant to the Department of Public Service if:

Any grant funds received are based on incorrect representations made on this application or to the Department of Public Service about this application; or any funds that are covered by other federal grants, federally forgiven loans, or state grant or loan funding received by the applicant for the same purpose. I agree that the final determination of whether there has been a duplication of benefits will be made by the Department of Public Service.

Consumer signature

School, Healthcare Provider, or Care Facility Representative (If applicable) Signature	
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