Dear Community Member,

The Global Economic Impact Group (GEIG) was established on the principles of providing economic and social impact to the community at large. It is our goal through the WHOOPITUP Program, which is a federally funded program, to distribute Android tablet and/or phones to individuals receiving any form of federal assistance. It is our goal through this program to distribute Android tablet/phones and internet access to the community at no cost, with the intended goal to close the digital divide within underrepresented communities.

It is the ultimate goal of GEIG to not only close the digital divide but connect communities and organizations to create positive educational programs and /or training opportunities and to share events or concerns that impact the community. Our hope is that the funding received from each tablet will be used to create positive information, training, and services for the community.

The potential outcomes in participating in this 'Community Benefits Program' include the following:

- Providing access to and closing the digital divide
- Proving a platform for the dissemination of positive information
- Providing internet connectivity throughout the community
- Providing economic resources to underserved or under-represented communities

If you have questions or would like more information regarding this program, please visit our website at www.whoopitup.us. You may also reach us at (559) 365-6781. We look forward to partnering with you to achieve these goals and to connect and inform our communities.

Sincerely,

Randall Cooper, Chief Executive Officer
Global Economic Impact Group

4672 W. Jennifer Ave., Suite 101 • Fresno, California 93722 • (559) 365-6781
www.geig.net • tablet@geig.net

GLOBAL ECONOMIC IMPACT GROUP

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whoopitup

FREE UNLIMITED TALK

FREE UNLIMITED TEXT
FREE 15GB OF DATA
APPLY FOR ANDROID TABLET*

NO CONTRACTS!
NO MONTHLY BILLS!
NO CREDIT CHECK!!

Services on one of America's Largest 4G LTE/5G Networks!

TO QUALIFY FOR THIS NO COST PROGRAM PARTICIPATE IN ONE OF THE FOLLOWING:

- Snap Program/Food Stamps
- Social Security
- Medicaid
- Section 8
- Pell Grant
- Veteran

For More Information. www.WhoopItUp.us

AFFORDABLE CONNECTIVITY PROGRAM
Helping Households Connect

Pell Grants

SNAP Supplemental Nutrition Assistance Program

National WIC Association

Medicaid

GLOBAL ECONOMIC IMPACT GROUP

USAC Affordable Connectivity Program

whoopitup

Community Benefit Program

Qualifying Participants

Snap Program/Food Stamps/EBT

Social Security

Medicaid

Section 8

Pell Grant

Veteran

Documented Immigrant

4672 W. Jennifer Ave., Suite 101 • Fresno, California 93722 • (559) 365-6781
www.geig.net • tablet@geig.net

Documents mandated to apply for a free Government tablet/phone in California

To apply for free government tablets in California, you need to have verified documents with application from that department you are using. If using your Social Security benefits, you need paperwork with benefits from social security office. If using SNAP/ Food Stamps, you need paperwork with case number and your name on the statement from department of social services.

You can provide any one of the following –

- Government offer letter
- Participation certificates
- Benefit award letter

If you qualify on an income basis, you will need a government source document showing your annual income statement.

You can submit one of the following documents –

- Current income statement or a paycheck stub
- A retirement/pension statement of benefits
- An Unemployment/Workmen's Compensation Statement of benefits
- A Social Security statement of benefits
- A Veteran Administration statement of benefits (VA cards alone are not accepted)
- Last year's state, federal, or tribal tax return

If you are required to supply more information for your program. Here are some helpful links and samples of the paperwork needed.

SNAP/EBT or MediCal : www.mybenefitscalwin.org

SSI: www.ssa.gov/myaccount

MediCaid/Social Security: Need proof of income or last years tax return

Section 8 Housing: www.ssa.gov/myaccount/

WIC: See attached form

Veteran Benefits: www.myhealth.va.gov/mhv-portal-web/user-login

4672 W. Jennifer Ave., Suite 101 • Fresno, California 93722 • (559) 365-6781
www.geig.net • tablet@geig.net

VERIFICATION OF RECEIPT OF MEDI-CAL

John Doe
555 ABC Road
Fresno, CA 93711-4785

Case Name:	John Doe
Case Number:	5B0LF47
Worker Name:	Service Center CW
Worker Number:	24CO
Worker Telephone:	(855) 832-8082
Date:	05/17/2023

This is to verify that John Doe _____ is currently receiving Medi-Cal.

His/Her share of cost is $0.00 per month.

Social Security Administration
Benefit Verification Letter

Date: May 18, 2023
BNC#: **5XR5Y58BT47**
REF: A

0101BEV3U3GT96B CCM.M72.BEV3U.R230518

JOHN DOE
555 YOUR ADDRESS
CITY, CA 93711

You asked us for information from your record. The information that you requested is shown below. If you want anyone else to have this information, you may send them this letter.

Information About Current Social Security Benefits

Beginning December 2022, the full monthly Social Security benefit before any deductions is $2,694.10.

We deduct $428.60 for medical insurance premiums each month.

The regular monthly Social Security payment is $2,265.00.
(We must round down to the whole dollar.)

Social Security benefits for a given month are paid the following month. (For example, Social Security benefits for March are paid in April.)

Your Social Security benefits are paid on or about the second Wednesday of each month.

Information About Past Social Security Benefits

From December 2021 to November 2022, the full monthly Social Security benefit before any deductions was $2,478.50.

We deducted $442.30 for medical insurance premiums each month.

The regular monthly Social Security payment was $2,036.00.
(We must round down to the whole dollar.)

Type of Social Security Benefit Information

You are entitled to monthly retirement benefits.

Medicare Information

You are entitled to hospital insurance under Medicare beginning May 2013.

See Next Page

You are entitled to medical insurance under Medicare beginning May 2013.

Your Medicare number is . You may use this number to get medical services while waiting for your Medicare card.

If you have any questions, please log into Medicare.gov, or call 1-800-MEDICARE (1-800-633-4227).

Date of Birth Information

The date of birth shown on our records is May 6, 1948.

Suspect Social Security Fraud?

Please visit http://oig.ssa.gov/r or call the Inspector General's Fraud Hotline at 1-800-269-0271 (TTY 1-866-501-2101).

If You Have Questions

Need more help?

1. Visit www.ssa.gov for fast, simple and secure online service.
2. Call us at **1-800-772-1213**, weekdays from 8:00 am to 7:00 pm. If you are deaf or hard of hearing, call TTY **1-800-325-0778**. Please mention this letter when you call.
3. You may also call your local office at **1-866-320-2587**.

SOCIAL SECURITY
510 COMMERCE CT
MANTECA CA 95336

How are we doing? Go to www.ssa.gov/feedback to tell us.

Social Security Administration

DEPARTMENT OF VETERANS AFFAIRS

June 12, 2023

John Doe
1234 Address
Anytown, CA 93245

In Reply Refer
to: xxx-xx-1234
27/eBenefits

Dear Mr. Doe:

This letter is a summary of benefits you currently receive from the Department of Veterans Affairs (VA). We are providing this letter to disabled Veterans to use in applying for benefits such as state or local property or vehicle tax relief, civil service preference, to obtain housing entitlements, free or reduced state park annual memberships, or any other program or entitlement in which verification of VA benefits is required. Please safeguard this important document. This letter is considered an official record of your VA entitlement.

Our records contain the following information:

Personal Claim Information

Your VA claim number is: xxx-xx-2229

You are the Veteran.

Military Information

Your most recent, verified periods of service (up to three) include:

Branch of Service	Character of Service	Entered Active Duty	Released/Discharged
Air Force	Honorable	October 01, 1986	February 05, 1987
Air Force	Honorable	January 25, 1991	April 25, 1991

(There may be additional periods of service not listed above.)

VA Benefit Information

You have one or more service-connected disabilities:	Yes
Your combined service-connected evaluation is:	70%
Your current monthly award amount is:	$1663.06
The effective date of the last change to your current award was:	December 01, 2022
You are considered to be totally and permanently disabled due solely to your service-connected disabilities:	No

You should contact your state or local office of Veterans' affairs for information on any tax, license, or fee-related benefits for which you may be eligible. State offices of Veterans' affairs are available at http://www.va.gov/statedva.htm.

How You Can Contact Us

- If you need general information about benefits and eligibility, please visit us at https://www.ebenefits.va.gov or http://www.va.gov.
- Call us at 1-800-827-1000. If you use a Telecommunications Device for the Deaf (TDD), the number is 1-800-829-4833.
- Ask a question on the Internet at https://www.va.gov/contact-us.

Sincerely Yours,

Regional Office Director

Women, Infants and Children (WIC)
California Department of Public Health, WIC Division
3901 Lennane Drive
Sacramento, CA 95834
1-800-852-5770 ● Email form to: WIC@CDPH.CA.GOV

Request for Verification of Participation in the California WIC Program

By submitting this form to the WIC Program, you are requesting verification of past or present participation in the California WIC Program for you and/or your child(ren). Please provide the following information:

1. I am a current or former WIC participant: ☐ Yes ☐ No

2. My relationship to the WIC participant(s) listed below is:
   ☐ Self ☐ Parent / Guardian ☐ Both

3. I am asking for verification of WIC participation for the following current or former WIC participant(s):
   Name: _____ Date of Birth: _____

   Name: _____ Date of Birth: _____

   Name: _____ Date of Birth: _____

   Name: _____ Date of Birth: _____

4. The address(es) for myself and/or my child(ren) while on the California WIC Program:
   _____
   _____

5. I would like to receive the verification of participation letter: ☐ By e-mail ☐ By mail

_____ _____ _____
Name of Participant/Parent/Guardian **(Printed)** **Signature** Date

_____
Current **e-mail address** for Participant/Parent/Guardian

_____
Current **phone number** for Participant/Parent/Guardian (**Optional)**

_____
Current **mailing address** for Participant/Parent/Guardian

IDENTIFICATION REQUIRED: Page 2 of this form must be completed for processing.

This institution is an equal opportunity provider.

Identification is required to process your request for verification of participation.

- **Current or former WIC participant – verification for self and/or minor child(ren):** If you are a current or former WIC participant requesting verification of participation for yourself and/or your minor child(ren), you must submit a copy of identification for yourself as described below. The identification must include your full name.

- **Non-participant parent or guardian – verification for minor child(ren):** If you are the parent or guardian of a current or former WIC participant and have never participated in the California WIC Program, you must submit a copy of identification for both yourself and your minor child(ren) as described below. Both forms of identification must include full names.

INSERT I.D. HERE
OR ATTACH TO
THIS FORM

INSERT I.D. HERE
OR ATTACH TO
THIS FORM

Identification Options for Adult Participant or Parent/Guardian: Aid Verification Letter/Notice of Action • Birth Certificate • Car/Vehicle Registration • Court Order • Foster Child Placement Letter/Notice • Immigration or Naturalization Papers • Immunization Record • Medi-Cal, Health, HMO, or County Services Access Card • Medical Records/Hospital Discharge Forms • Medical Referral Form • Military ID • Official School Documents/Financial Aid Documents • Paystub/Checks with Pre-Printed Name/Bank Documents • Photo Identification (Driver's License/Passport) • Rent/Mortgage/Lease/Property Tax Statement • School ID Card • Social Security Card • Tribal ID Card • Unemployment Benefits Card/Letter • Voter Registration • Work ID Card

Identification Options for Infant/Child Participant: Adoption Papers • Aid Verification Letter/Notice of Action • Baptismal Certificate • Birth Certificate/Hospital Birth Verification/Crib Card • Court Order • Foster Child Placement Letter/Notice • Immigration or Naturalization Papers • Immunization Record • Medi-Cal, Health, HMO, or County Services Access Card • Medical Records/Hospital Discharge Forms • Medical Referral Form • Official School Documents • Photo Identification/Passport • Social Security Card • Tribal ID Card

ACP Application

Rules

If you qualify, your household can receive a monthly Affordable Connectivity Program (ACP) you will receive a tablet, or laptop with a copayment of $0 and a monthly payment of $0. Your household cannot get the ACP benefit from more than one company. You are only allowed to get one ACP benefit per household, not per person**. If there are additional qualified applicants under one household, please complete the Household Worksheet attached.**

The Affordable Connectivity Program is separate from the FCC's Lifeline Program. If your household qualifies for both programs, you can apply for and receive both benefits.

You may need to show other documents.

If the ACP Administrator is not able to validate that you or someone in your household qualify by checking available electronic resources (including eligibility databases for the FCC's government agency partners), you may need to provide additional documents.

For example, you may need to provide an official document that proves your child's participation in the Reduced/Free Lunch Program. If additional documentation is required, an ACP agent will contact you using the information provided on the application.

What is your full legal name?

The name you use on official documents, like your Social Security Card or State ID. Not a nickname.

First _____ Middle (optional) _____ Last _____

Phone Number _____ Date of Birth _____

Email _____

Do you or anyone in your household currently receive ACP benefits? Yes_____ No_____

If marked yes, please answer the following: Is the person yourself? Yes_____ No_____

If not, do you and this person share household expenses? Yes_____ No_____

****Identity Verification. Please provide the last four digits of your SSN#.** _____ _____ _____ _____

Referring organization: _____

Referring Contact Person: _____

What is the home address? (The address where you will get service. Do not use a P.O. Box)

Street number and Street name _____

Apt., Unit, etc. _____ City _____ State_____ Zip Code_____

Is this a temporary address? Yes _____ No_____

What is your mailing address? (Only fill this out if it is not the same as your home address.)

Street number and Street name _____

Apt., Unit, etc. _____ City _____ State_____ Zip Code_____

If the qualifying applicant is under the age of 18, enter their information below:

What is your full legal name?

First _____ Middle (optional) _____ Last _____

Student's Date of Birth _____ Student's Email (optional) _____

****Identity Verification. Please provide the last four digits of students SSN#.** _____ _____ _____ _____

Qualify for the ACP

Fill out this section to show that you, your dependent, or someone in your household qualifies for the ACP. You can qualify through certain government assistance programs or through your income (you do not need to qualify through both).

Please select the government program you currently participate in

- ○ Social Security
- ○ Snap Program/Food Stamps/EBT
- ○ Medicaid or MediCal
- ○ Section 8
- ○ Pell Grant (enter school name/state below)
- ○ Veteran (VA benefits letter)
- ○ Documented Immigrant

Attach needed documents:

Agreement

I agree, under penalty of perjury, with the following statements: ***You must initial next to each statement. If you fail to initial each statement, your application will be considered incomplete.***

_____ By providing a phone number, you consent to letting USAC contact you at that phone number via artificial or prerecorded voice message or text for important reminders and updates about your ACP benefit. For text messages, message and data rates may apply. Text STOP to end messages.

_____ I (or my dependent or other person in my household) currently get benefits from the government program(s) listed on this form or my annual household income is 200% or less than the Federal Poverty Guidelines (the amount listed in the Federal Poverty Guidelines table on this form).

_____ I agree that if I move, I will give my service provider my new address within 30 days.

_____ I understand that I have to tell my service provider within 30 days if I do not qualify for the ACP anymore, including:

1) I, or the person in my household that qualifies, do not qualify through a government program or income anymore.

2) Either I or someone in my household gets more than one ACP benefit.

_____ I know that my household can only get one ACP benefit, and, to the best of my knowledge, my household is not getting more than one ACP benefit. I understand that I can only receive one connected device (desktop, laptop, or tablet) through the ACP, even if I switch ACP companies.

_____ 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 or Tribal government require it, I agree that the state or Tribal government may share information about my benefits for a qualifying program with the ACP Administrator. The information shared by the state or Tribal government will be used only to help find out if I can get an ACP benefit.

_____ For my household, I affirm and understand that the ACP is a federal government subsidy that reduces my broadband internet access service bill and at the conclusion of the program, my household will be subject to the company's undiscounted general rates, terms, and conditions if my household chooses to continue to subscribe to the service.

_____ For my household, I affirm and understand that the ACP is a federal government subsidy that reduces my broadband internet access service bill and at the conclusion of the program, my household will be subject to the company's undiscounted general rates, terms, and conditions if my household continues to subscribe to the service.

_____ 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.

_____ The ACP Administrator or my service provider may have to check whether I still qualify at any time. If I need to recertify my ACP benefit, I understand that I have to respond by the deadline or I will be removed from the Affordable Connectivity Program and my ACP benefit will stop.

I was truthful about whether I am a resident of Tribal lands, as defined in the "Your Information" section of this form. We do not use your information except to verify your eligibility for the ACP program. We do not sell your information to any third party companies

Signature: _____ Today's Date: _____