RESIDENTIAL CRITICAL CARE AND CHRONIC CONDITION APPLICATION

IMPORTANT INFORMATION:

- This application must be completed to obtain Chronic or Critical Care designation.
- This application will not be processed if incomplete, unreadable, or improperly submitted.
- All information is required, unless otherwise indicated.
- Submission of this application does not automatically result in Critical Care or Chronic designation.
- Customer will be notified upon approval and when the designation is due for renewal.
- Pursuant to the Tariff and Business Rules of the City, designation as a Chronic or Critical Care residential customer does not relieve a customer of the obligation to pay for electric service, and service may be disconnected for failure to pay.
- Chronic or Critical Care designation does not guarantee continuous electric power.
- If electricity is a necessity to sustain life, you must make other arrangements for on-site back-up capabilities or other alternatives in the event of power loss.
- It is important that we have the most current phone number and mailing address on record.

INSTRUCTIONS FOR RESIDENTIAL CRITICAL CARE or CHRONIC CONDITION PROGRAM APPLICATION:

APPLICANT: Complete Part 1 of application and provide to patient's physician to complete

PHYSICIAN: Complete Part 2 of application

APPLICANT: Return signed application to City office or via email, fax, or mail

CRITICAL CARE AND CHRONIC CONDITION APPLICATION FORM

PART 1: COMPLETED BY THE CUSTOMER- ALL INFORMATION IS REQUIRED

Name on City account: ______________________________

Patient name: ______________________________

(Name of Patient living permanently at the Service Location who requires chronic condition or critical designation
(The Patient may be the same person as the Customer.)

Account number ______________________________ Generator? __________

Service location on your bill: ______________________________

City: ______________________________ State: ______________ Zip: ______________

Mailing address on your City bill: ______________________________

City: ______________________________ State: ______________ Zip: ______________

Primary phone: ______________________________ Alternate phone (if any): ______________________________

Emergency (Secondary) Contact Information (Your application will be rejected unless you include an Emergency Contact name or insert "I choose not to provide an Emergency Contact name."

Emergency contact: ______________________________

Mailing address: ______________________________

City: ______________________________ State: ______________ Zip: ______________

Primary phone: ______________________________ Alternate phone (if any): ______________________________

APPLICANT – I have read and understood City's information on the Residential Critical Care and Chronic Condition Form and certify that the information provided on this application is correct.

I understand the information may also be used to determine whether I am eligible for additional notices relating to my electric service. I agree to be contacted by telephone at the phone numbers listed above with respect to the Program. City is not liable for delayed or undelivered notifications.

PATIENT/PATIENTS GUARDIAN, PARENT, OR MANAGING CONSERVATOR – I have read and understood the information on the Critical Care and Chronic Condition Form and certify that the information provided in this application about me (or the patient) is correct. I agree to the release of the information on this form concerning my (or the patient's) medical condition for the purposes stated on this application.

CRITICAL CARE AND CHRONIC CONDITION APPLICATION FORM (CONTINUED)

PART 2: COMPLETED BY THE PATIENT'S PHYSCIAN – ALL INFORMATION IS REQUIRED

CHRONIC CONDITION:	**YES**	**NO**
The patient has a serious medical condition that requires an electric-powered medical device or electric heating or cooling to prevent impairment of a major life function through a significant deterioration or exacerbation of the person's medical condidtion.	☐	☐
If yes to the above, has the medical condition been diagnosed as a life-long condition?	☐	☐

OR

CRITICAL CARE CONDITION:	**YES**	**NO**
The patient is dependent upon an electric-powered medical device to sustain life.	☐	☐
If yes to the above, has the medical condition been diagnosed as a life-long condition?	☐	☐

Physician name (please print): ____________________

Texas Medical Board License number: ____________________

Phone: ____________________

Physician signature: ____________________