

Medical Life Support Program Application

Attach to completed Utility Rate Assistance Program application.

Program applied for:
Medical Life Support
Medical Rate Assistance

Details and requirements for the Medical Rate Assistance Program can be found in the Utility Rate Assistance Program (URAP) application. Attach this form to the URAP application.

Instructions for Supplemental Application:

- Part 1 Completed by Account Holder/Applicant.
Part 2 Completed by Medical Doctor licensed to practice medicine in the State of California.

Applicant Information

Part 1

ACCOUNT HOLDER NAME (AS IT APPEARS ON UTILITY BILL — LAST NAME, FIRST NAME, MIDDLE INITIAL)		UTILITY ACCOUNT NUMBER
		X X X - X X -
PATIENT NAME	SOCIAL SECURITY NUMBER (LAST 4 DIGITS ONLY)	RELATIONSHIP
		()
PROPERTY ADDRESS	ZIP	PHONE NUMBER
MAILING ADDRESS (IF DIFFERENT THAN ABOVE)	ZIP	

Type of Equipment Required by the Patient (Please Include Make, Model, Voltage, and Wattage Information):

MAKE	MODEL	VOLTAGE	WATTAGE
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Agreement

I certify under penalty of perjury, that the above information indicated by me is true and correct. I also understand that the above information is subject to verification and I agree to provide such verification and understand I will be denied without this verification. I understand it is my responsibility to notify the City of Roseville when the person using the medical equipment either no longer uses the device or resides at this location.

If you or a family member are dependent upon life support or medical equipment and an outage is causing a life threatening emergency, call 911. Trained emergency medical personnel are ready and available to assist you during an outage or during any emergency.

By signing below, I declare under penalty of perjury that the information contained on this application is true and correct.

Mail Completed Application to:

City of Roseville
Finance Department
311 Vernon Street
Roseville, CA 95747-9704
Call: (916) 774-5300 or (916) 79-POWER (797-6937) for more Information
or visit us at www.roseville.ca.us/electric
or www.roseville.ca.us

For City Use Only

ACCT NO.	
EFFECTIVE DATE	
APPROVAL	YES / NO
AUTHORIZED BY	
NOTES:	

APPLICANT SIGNATURE _____ DATE _____



Statement of Certification

Part 2

PATIENT NAME

Type of Equipment Required by the Patient (Please Include Make, Model, Voltage, and Wattage Information):

MAKE

MODEL

VOLTAGE

WATTAGE

For disabled persons requiring energy for special electric heat or air conditioning needs, complete:

- Paraplegic, hemiplegic or quadriplegic requiring special heat and/or air conditioning.
- Multiple sclerosis patient requiring special electric heat and/or air conditioning.

To be eligible for a rate discount, an essential medical support device is defined as any medical device requiring utility supplied electrical energy for its operation and which is required to support the life of a person residing in a residential dwelling. In your opinion does the equipment above meet this description?:

- Yes
- No

How long can the patient cope without electricity before a life-threatening medical condition arises?

Hours: Minutes:

How long will the patient be required to use such equipment?

- Less than a year
- 1-2 Years
- Life-time
- Other: _____

Can the electrically-powered equipment be operated by an auxiliary source such as a hand pump (crank) or battery?

- Yes
- No
- If yes, how long: _____

I hereby certify that this patient regularly requires the use of the above life supporting medical equipment that is powered by electricity.

DOCTOR'S SIGNATURE

DATE

PRINT NAME

CALIFORNIA MEDICAL LICENSE NUMBER

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PHONE NUMBER

ADDRESS

CITY

ZIP

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ON LIFE SUPPORT LIST:	
DATE MED SEAL INSTALLED:	
INSTALLED BY:	
MEDICAL SEAL NO:	
SEAL NO. ENTERED:	
METER NO:	