

Date:

Customer Name:

Mailing Address:

City, CA ZipCode:

MID Account Number:

### **NOTICE – APPLICATION FOR MEDICAL LIFE SUPPORT RATE**

Modesto Irrigation District offers a discounted rate for customers that require electric power for life sustaining devices. The Medical Life Support Rate allows for 50% off the first 500 kWh used during each billing cycle. A life support device is defined as a device used to sustain life or relied upon for mobility. This rate is also available if the patient has a compromised immune system, life threatening illness, or any other condition for which heating or cooling is medically necessary to sustain the person's life or prevent deterioration of the medical condition

To qualify for a Medical Life Support Rate, this device must be used in the home and must run on electricity supplied by the District. The term "life support device" includes, but is not limited to, respirators, iron lungs, hemodialysis machines, suction machines, electric nerve stimulators, pressure pads and pumps, aerosol tents, electrostatic and ultrasonic nebulizers, compressors, IPPB machines, and motorized wheelchairs. Devices used for therapy rather than for life support generally do not qualify.

#### **Eligibility is based on all of the following conditions:**

- A customer or dependent that is a full time member of the household uses a life support device, or has a severe medical condition which requires heating/cooling to sustain life.
- A District-approved Medical Life Support Rate Acceptance Form is on file.
- A customer account under the Medical Life Support Rate is re-certified annually.

#### **Participation:**

Please remember that it is your responsibility to keep your bill current to prevent any interruption of your electric service. The customer is solely responsible for continuous electric service in the event of power outages or disconnection of service due to non-payment. The District does not and cannot guarantee 100% service at all times. Therefore, the District recommends installation of a source of backup power as a possible prevention of service interruptions.

#### **Application:**

Attached is the Medical Life Support Rate Acceptance Form. The form includes Customer and Physician Certification. After the form is completed by the customer and the physician, the completed form must be returned to MID. Once the form is approved, you will receive a notice confirming that your Medical Life Support Rate is in effect.

If you have any questions please contact Energy Services at (209) 526-7435 or Customer Services at (209) 526-7337.

# Medical Life Support Rate Acceptance Form

(Please read other side)

<b>Customer Certification</b> (This section to be completed by Customer)		
<b>Customer Information</b>		
Account Name	Account Number	Contact Phone Number
Service Address	City	Zip Code
Mailing Address (if different than above)	City, State	Zip Code
<b>Patient Information</b>		
Patient Name	Relationship to Customer	Patient Date of Birth
Patient Address	City	Zip Code
I certify that the above information is correct. I agree to allow a District representative to enter my premises during reasonable hours to verify this information. I understand that if I refuse to let Modesto Irrigation District verify this information, the Medical Life Support Rate will be discontinued.  I understand that this declaration is valid for <u>one year</u> starting on the date the application is approved by MID, and that Modesto Irrigation District will annually review my eligibility for this rate.  Further, I understand that the purpose of this rate program is solely to reduce the cost of electric service provided by Modesto Irrigation District and in no way guarantees continuous service. I understand that it is my responsibility to keep my bill current to prevent any interruption of electric service due to non-payment.  I understand the recommendation for a backup power device to prevent interruption of electric service in the event of a power outage or disconnection due to non-payment, and that the District cannot guarantee continuous service at any time.		
Customer Signature		Date

<b>Physician Certification</b> (This section to be completed by Physician)		
<b>Patient Information</b>		
Patient Name	Relationship to Customer	Patient Date of Birth
Patient Address	City	Zip Code
<b>Patient Medical Condition</b>		
<b>In what way does this require additional electricity?</b> <span style="float: right;">Conditions requiring extra electricity, or heating and / or cooling in the home:</span>		
Paraplegic <input type="checkbox"/> Quadriplegic <input type="checkbox"/> Hemiplegic <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Scleroderma <input type="checkbox"/> Other <input type="checkbox"/> (please detail below)		
<u>Notes, comments, medical condition, life support devices:</u>   		
I hereby certify that the life support devices and/or additional heating and cooling will be required for <input type="checkbox"/> Number of years _____ <input type="checkbox"/> Permanently		
Physician's Name		Phone Number
MD / DO License Number		
Physician Signature		Date