Medical Life Support Application

Medical Discount Program

How to Apply

1. Enter your account information.
2. Enter household and income information.
3. Attach proof of total monthly income. **MID will not accept bank statements as proof of gross income. If adults are listed on the application without proof of income, please attach an explanation.**
4. Sign and date the application. Return the application and proof of income to: **MID MLS, P.O. Box 4060, Modesto, CA 95352-4060 or email to MIDCares@mid.org. Incomplete applications will not be processed.**

1. Application Information

Customer Name (as appears on MID bill)	MID Account #		
Service Address	City	State	Zip Code
Mailing Address (if different than above)	City	State	Zip Code
Phone Number	E-mail Address		

2. Household Information & Income Verification

Total number of persons living in the home (full-time basis): Adults _____ + Minors (under 18) _____ = _____ Total

MID will no longer accept bank statements as proof of gross income. If you need a copy of your Social Security Award Letter, please contact the local Social Security office by calling **1-800-772-1213.** Documents will not be returned. Household income includes money from all household members (taxable or non-taxable), including but not limited to:

Wages $ _____	TANF (AFDC) $ _____	Spousal support $ _____
Interest income $ _____	Child support $ _____	Rental or royalty income $ _____
Social Security $ _____	Disability payments $ _____	Legal settlements $ _____
SSI, SSP, SSDI $ _____	Workers compensation $ _____	Scholarships or Grants $ _____
Pensions $ _____	Unemployment benefits $ _____	Cash received monthly $ _____
		Self-employed (IRS Form Schedule C required) $ _____

Other income (explain):_____ $ _____

Total Monthly Household Income (Gross): $ _____

Monthly household income must be $8,356 or less to qualify. Effective 03/01/2024

3. Required Documentation

Please verify the following information is complete and attached:

☐ Proof of all income for one month for all household members ☐ Complete Physician Certification

3. Declaration and Signature

MID cannot guarantee uninterrupted electric service. I am responsible for continuous electric service in the event of power outages or disconnection of service due to non-payment.

The information on this application and required documentation is used to determine and verify my eligibility for assistance. **All information is confidential and is not shared with outside agencies.** It is the customer's responsibility to contact MID if your household income increases above the current limits and/or if the patient no longer requires the medical device(s). MID reserves the right to request further certification at any time while the MID customer is on the program. Misrepresentation of information, failure to disclose all income or failure to provide additional documentation, including tax records, as requested by MID, may result in disqualification in the MLS program. MID will charge the customer the amount of the MLS discount inappropriately received in accordance with the MID Electric Service Rules.

If eligible for MLS discount, I permit the proper change to the rate schedule for the service address listed above and give consent to have my eligibility verified. I declare, under penalty of perjury, that the information on this application is true and correct.

X

Signature (person whose name appears on MID bill) Date

STOP **Please have your physician complete page 2 (back page) of this application before mailing to MID.**

March 2024

For Physician Use Only

Page 2: To be completed by a Doctor of Medicine or Osteopath, licensed to practice in the State of California

1. Patient Information

Patient Name	Patient Date of Birth	Relationship to Customer

2. Life Support Device *(Electrically Powered)*

☐ Yes ☐ No **IPPB**

☐ Yes ☐ No **Oxygen Concentrator**

☐ Yes ☐ No **Electric Wheelchair**

☐ Yes ☐ No **In-Home Dialysis Cycler**

☐ Yes ☐ No **Other Equipment** (description): _____

Devices used for therapy rather than life support do not qualify. Equipment must be plugged in and not battery operated.

3. Special Electric Heating and Cooling Needs

Medical discount is available for special heating and/or cooling needs if the patient is:

☐ Paraplegic ☐ Quadriplegic ☐ Hemiplegic ☐ Multiple Sclerosis ☐ Scleroderma

Heating or cooling is medically necessary to sustain the person's life or prevent deterioration of the person's medical condition:

☐ Yes ☐ No **Special Cooling Needs** (description): _____

_____

☐ Yes ☐ No **Special Heating Needs** (description): _____

_____

4. Physician Certification *(MD or DO)*

Diagnosis / Medical Condition

I certify that the life support device(s) and/or additional heating or cooling will be required for a minimum of 12 months.
Duration of medical condition: _____
Permanent (Check One)

☐ Yes ☐ No *Permanent: not expected to change for an indefinite time; not temporary.

Does interruption in power cause a potentially life-threatening medical condition? ☐ Yes ☐ No

Physician's Name	Phone Number		
Office Address	City	State	Zip Code
California Medical License Number	Fax Number		
Physician Signature X		Date	

MID Use Only

Approved ☐ Yes ☐ No	ES Staff	Date	**Reason for Disqualification:**
Recertification Required: ☐ Annually ☐ Every 3 Years	ES Supervisor	Date	☐ Equipment does not qualify ☐ Heating/Cooling needs do not qualify ☐ Income does not qualify ☐ Application Incomplete