

PART 1 TO BE COMPLETED BY CUSTOMER (please print)

Liberty Account #:		
Customer Name (as it appears on your bill):		
Medical Baseline Resident's Name (if different):		
Service Address:		
Customer Mailing Address (if different):		
Home Phone: () Work Phone: ()	
For Customers Billed by Someone other than Liberty		
Name of Mobile Home Park or Apartment Complex:		
Complex Address:		
Complex Manager's Name:	Complex Phone: ()
Name of Tenant:	Tenant's Phone: ()
I understand that:		

- 1. If the qualified medical professional certifies the resident's medical condition is permanent, Liberty will require completion of a form self-certifying that the resident continues to be eligible for Medical Baseline every two years.
 - 2. If the qualified medical professional certifies the resident's medical condition is not permanent, Liberty will require the completion of a form self-certifying the resident's eligibility for Medical Baseline each year and completion of a new application with a qualified medical professional's certification every two years.
- 3. Liberty cannot guarantee uninterrupted electric service and I am responsible for making alternate arrangements in the event of an electric outage.

I certify that the above information is correct. I also certify that the Medical Baseline Resident lives full-time at this address and requires or continues to require the Medical Baseline Allowance. I agree to allow Liberty to verify this information.

I also agree to promptly notify Liberty if the qualified Resident moves or Medical Baseline Allowance is no longer needed by the resident.

Customer Signature: Date:



PART 2 TO BE COMPLETED BY A LICENSED MEDICAL DOCTOR (M.D.), DOCTOR OF OSTEOPATHY (D.O.)., PHYSICIAN'S ASSISTANT, OR NURSE PRACTITIONER

I certify that the medical condition and needs of my patient (please print):

Last	Name	First Name	;				
1.	<u>Requires use of a life</u>	-support device*(check one)	YES		0		
The following life-support device(s) is/are used in the above-named patient's home:							
	Device:HOURS/DA						
Device:				HOURS/DAY:			
	Device:	RS/DAY:					
nebulize	ers, compressors, IBB ma e-support do not qualif <u>Requires heating and</u> Standard Medical Bas and Hemiplegic, has M	<u>cooling:</u> eline Allowances are available for heatin fultiple Sclerosis or Scleroderma. Stand	notorized wheelchairs. ng and/or cooling if pati ard Medical Baseline A	Devices us ent is Para llowances	sed for therapy rather aplegic, Quadriplegic, are also available if a		
	patient has a compromised immune system, life threatening illness, or any other condition for which additional heating or cooling is medically necessary to sustain the person's life or prevent deterioration of the person's medical condition.						
	Requires Standard Me	lical Baseline Allowance for <i>heating</i> :	(check one)	YES			
	Requires Standard Me	dical Baseline Allowance for <i>cooling:</i>	(check one)	YES			
3.	3. <u>I certify that the life support device(s) and/or additional heating or cooling will be required for approximately:</u>						
	(Complete one)	# of Years	OR	□Pe	ermanently		
Qualifi	ed Medical Profession	al's Name:	Phon	e #: ()		
Office .	Address:						
MD/DO	O California State Lice	ense or Military License Number:					
<u>Signatu</u>	re of Qualified Medica	al Professional:	Date	:			
FOR LI	BERTY USE ONLY:		Date Received:				

Recertification: Self-certify every 2 years Self-certify annually; Qualified Medical Professional's certification every 2 years

Mail To: Liberty Utilities (CalPeco Electric) LLC, Attn: Medical Baseline, 933 Eloise Ave., South Lake Tahoe CA 96150