

## 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<br>e-support do not qualif<br><u>Requires heating and</u><br>Standard Medical Bas<br>and Hemiplegic, has M   | <u>cooling:</u><br>eline Allowances are available for heatin<br>fultiple Sclerosis or Scleroderma. Stand | notorized wheelchairs.<br>ng and/or cooling if pati<br>ard Medical Baseline A | <b>Devices us</b><br>ent is Para<br>llowances | sed for therapy rather<br>aplegic, Quadriplegic,<br>are also available if a |  |  |
|   | patient has a compromised immune system, life threatening illness, or any other condition for which additional heating<br>or cooling is medically necessary to sustain the person's life or prevent deterioration of the person's<br>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