Liberty Utilities

MEDICAL BASELINE ALLOWANCE APPLICATION *Used for Medical Baseline Enrollment and Re-Certification*

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 doctor 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 doctor 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 doctor'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:

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PART 2 TO BE COMPLETED BY A LICENSED MEDICAL DOCTOR (M.D.) OR DOCTOR OF OSTEOPATHY (D.O.).

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

Last Name First Name

1. **Requires use of a life-support device*(*check one*)** ☐**YES** ☐**NO**

   The following life-support device(s) is/are used in the above named patient's home:

   Device:_____ HOURS/DAY:_____

   Device:_____ HOURS/DAY:_____

   Device:_____ HOURS/DAY:_____

*A qualifying life-support device is any medical device used to sustain life or is relied upon for mobility. This device must run on electricity supplied by Liberty. It includes, but is not limited to, respirators (oxygen concentrators), iron lungs, hemodialysis machines, suction machines, electric nerve stimulators, pressure pads and pumps, aerosol tents, electrostatic and ultrasonic nebulizers, compressors, IBB machines, kidney dialysis machines, and motorized wheelchairs. **Devices used for therapy rather than life-support do not qualify.**

2. **Requires heating and cooling:**

   Standard Medical Baseline Allowances are available for heating and/or cooling if patient is Paraplegic, Quadriplegic, and Hemiplegic, has Multiple Sclerosis or Scleroderma. Standard Medical Baseline Allowances 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 Medical Baseline Allowance for ***heating:*** (*check one*) ☐ **YES** ☐**NO**

   Requires Standard Medical Baseline Allowance for ***cooling:*** (*check one*) ☐ **YES** ☐**NO**

3. **I certify that the life support device(s) and/or additional heating or cooling will be required for approximately:**

   (*Complete one*) ☐**# of Years_____** **OR** ☐**Permanently**

Doctor's Name: Phone #: ( )

Office Address:

MD/DO California State License or Military License Number:

Signature of Doctor: Date:

FOR LIBERTY USE ONLY : Date Received: _____

Recertification: ☐Self-certify every 2 years ☐Self-certify annually; Doctor's certification every 2 years

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