MEDICAL BASELINE ALLOWANCE APPLICATION

PART 1: TO BE COMPLETED BY CUSTOMER

City of Banning Account Number: _____

Customer Name *(as it appears on your bill)*: _____

Medical Baseline resident's name *(if different)*: _____

Service Address: _____

Cell Phone: _____ Home Phone: _____

I understand that:

1. I must submit a new application with a doctor's certification every two years. The Electric Utility will mail me a reminder along with the necessary forms when it is time to reapply. If a resident is visually or otherwise impaired, I can call the Electric Utility to request special notification of when the mailing is to be sent out for reapplication.

2. The City of Banning cannot guarantee uninterrupted water and electric service and I am responsible for making alternate arrangements in the event of an outage or if service is interrupted for reasons including but not limited to non-payment.

I certify under penalty of perjury that the information is true and correct to the best of my knowledge. I also certify that the Medical Baseline resident lives full-time at this address, and requires or continues to require Medical Baseline Allowance. I agree to allow the City of Banning to verify this information. I also agree to promptly notify the City of Banning if the qualified resident moves or Medical Baseline Allowance is no longer needed by the resident.

I understand that if it is discovered that I am receiving benefits without meeting eligibility criteria then I may be required to reimburse the Electric Utility for up to one year of the benefits incorrectly received.

Customer Signature: _____ Date: _____

The standard Medical Baseline Allowance is 500 kilo-watt hours per billing cycle, which is in addition to your standard Baseline Allocation.

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

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

_____ _____

Last Name First Name

1. Requires the use of a life-support device*: Yes _____No _____ (Check One)

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

   Device(s): _____

   * A qualifying life-support device is any medical device used to sustain life or is relied upon for mobility. This devise must run on electricity supplied by the City of Banning. 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, IPPB machines, kidney dialysis machines and motorized wheelchairs. Devices used for therapy rather than life-support do not qualify.

2. Requires additional cooling and/or heating:

   Standard Medical Baseline Allowances are available for additional cooling and/or heating if patient is paraplegic, quadriplegic, and hemiplegic, has multiple sclerosis or scleroderma. Standard Medical Baseline Allowances are also available if patient has compromised immune system or life threatening illness for which additional cooling or heating is medically necessary to sustain the person's life or prevent deterioration of the person's medical condition.

   Requires Standard Medical Baseline Allowance for cooling: Yes _____ No_____ (Check One)

   Requires Standard Medical Baseline Allowance for heating: Yes _____ No_____ (Check One)

   If "Yes", please indicate your patient's medical condition that requires additional cooling or heating:

   Medical Condition: _____

   Doctor's Name: _____Phone #: _____

   Office Address: _____

   MD/DO California State License or Military License Number: _____

   SIGNATURE OF DOCTOR:_____DATE: _____