# *City of Ukiah*

## DECLARATION OF ELIGIBILITY FOR ADDITIONAL MEDICAL BASELINE QUANTITY

Customer Name:_____ Date:_____

Service Location:_____ Customer No:_____

Emergency Contact

Daytime Phone Number:_____ Telephone No.:_____

I DECLARE THAT I AM ELIGIBLE FOR ADDITIONAL MEDICAL BASELINE QUANTITY UNDER PROVISIONS OF CITY OF UKIAH'S APPLICABLE RESIDENTIAL SERVICE RATE SCHEDULES. MYSELF OR A FULL-TIME RESIDENT IN MY HOME IS DEPENDENT ON A LIFE-SUPPORT DEVICE OR MUST LIVE IN A CONTROLLED TEMPERATURE ENVIRONMENT.

PLEASE COMPLETE APPLICABLE SECTION(S):

**LIFE SUPPORT DEVICE:** A life-support device is any medical device used to sustain life or relied upon for mobility. To qualify you for a Medical Baseline Quantity, this device must be used in the home and must run on electricity supplied by the City of Ukiah. The term life-support device includes, but is not limited to: respirators, iron lungs, hemodialysis machines, electric nerve simulators, pressure pads and pumps, aerosol tents, electrostatic and ultrasonic nebulizers, compressors, IPPS machines, and motorized wheelchairs. Devices used for therapy rather than for life-support do not qualify.

*Type of Device*

___LIFE SUPPORT DEVICE(S):_____

_____

_____

**SPACE CONDITIONING:** Medical baseline quantities are available for certain qualified disabled persons requiring City of Ukiah supplied energy for space heating air conditioning needs (check all that apply):

____multiple-sclerosis patient ___quadriplegic person

____hemiplegic person ___paraplegic person

____other medical condition:_____

I HEAT MY HOME MAINLY WITH: ___GAS ____ELECTRICITY

I certify under penalty of perjury that the information above is correct. I agree to allow a City of Ukiah representative enter my home during reasonable hours to verify this information. I understand that if I refuse to allow the City of Ukiah to verify this information, I will lose my additional medical baseline quantity. The City has the right to verify and confirm the information in this application before allocating the additional baseline allowance.

I understand that this information declaration is valid for one (1) year starting on the date shown below. The City of Ukiah will review the declaration after one (1) year and either 1) allow it to remain in effect beyond that one (1) year period or 2) notify me that I must complete a new declaration.

It is the resident(s) responsibility to notify the City of Ukiah (Billing Department) immediately if the person qualifying for Standard Medical Baseline Quantity moves to another service address or if he/she no longer requires the additional Standard Medical Baseline Quantity.

The Standard Medical Baseline Quantity is an additional 500 kilowatt-hours (KWH) per month to the baseline usage. If these quantities do not meet your medical needs please contact the City of Ukiah, Billing Department at (707) 463-6228. You may be eligible for additional Medical Baseline Quantities.

_____

(Applicant's signature) (Date)

**Please have a Doctor of Medicine or Osteopathy Certify Your Eligibility on the back of this form.**

# CERTIFICATION OF DOCTOR OF MEDICINE OR OSTEOPATHY LICENSED TO PRACTICE MEDICINE IN THE STATE OF CALIFORNIA

I certify that the medial condition and needs of _____
(Name of Patient)
who is a full-time resident of the customer's household, are as follows:

(Please fill in the medical condition of the patient and any special needs required)

_____

_____

_____

_____

_____

_____

If you wish to explain in more detail, please attach your signed statement.

**Life-Support Device:** Where customer/patient has indicated the need for using a medical *life-support device,* is such device essential to sustain the patient's life?

____yes ___no (One of these two boxes **must** be checked).

**Space Conditioning** (Complete this section if medical condition is other than paraplegia, quadriplegia, hemiplegia, or multiple sclerosis): Where customer/patient has indicated a special need for heating and/or air conditioning, is this space conditioning essential to sustain the patient's life?

____yes ___no (One of these two boxes **must** be checked).

Doctor's Name:_____
(Please print or type)

Signature:_____

Office Address:_____

Telephone Number:_____