LIFE-SUPPORT RATE APPLICATION

Gridley Municipal Utilities
685 Kentucky Street, Gridley, Ca. 95948
Office (530) 846-5695 fax (530) 846-3229

CUSTOMER INFORMATION

Customer Id No.: _____ *Route No.* _____

Account Holders Name: _____

Service Location: _____

Life Support Residents Name _____

Service Address: _____

Mailing Address (if different) _____

Home Phone: ( ) _____ Work Phone: ( ) _____

Customer Agrees and Understands the following:

1. Customer agrees to notify the City of Gridley Municipal Utilities Department in writing, in the event of the following; the life-support applicant no longer qualifies or requires life-support rate, applicant is moving from the above service location, and/or relocating to another service location.
2. If the medical condition is not permanent, the customer agrees to submit another certification as before the expiration date as noted by the physician (Section B).
3. The City of Gridley Municipal Utilities does not guarantee electrical services and in the event of an outage, customer is responsible for alternative power source.
4. The Life-Support Rate will only be applied to the first (1st) tier of the rate structure and rate may be subject to change by the City of Gridley.

I certify that the information I have provided is correct and that the Life-Support Resident lives at this address and is requiring the Life-Support Rate. I authorize the Gridley Municipal Utilities to verify this information if needed.

Customer Signature: _____ **Date:** _____

****

For official use only

Date Received: _____ ☐ ***Approved (____) initials*** ☐ ***Denied (____) initials***

Recertification: ☐ ***None (permanent condition)*** ☐ ***Annually(December)*** ☐ ***other:*** _____

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

(In lieu of form doctor may attach recommendations)

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

_____

Last Name **First Name**

Section A Requires use of a life-support device* (check one) ☐ Yes ☐ No

*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 the City of Gridley. 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.

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

Device: _____

Life-Support Baseline Program is available for heating and/or cooling if patient is Paraplegic, Quadriplegic, Hemiplegic, has Multiple Sclerosis or Scleroderma. Also if the patient has 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.

Section B Certification of Physician

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

(complete one) ☐ No. of years _____ or ☐ Permanent

Doctor's Name: _____ Phone No. ( ) _____

Office Address: _____

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

Signature of Doctor: _____ **Date:** _____