



Declaration of Eligibility for a Standard Medical Baseline Quantity

Mail Completed Application to P.O. Box 2288, Merced, CA 95344-0288
For Questions Call: (209) 722-3041

Customer to complete the following (please print): MID Account No. _____

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

Patient's Name (if different): _____

Service Address: _____

Number and Street City Zip

Mailing Address (if different): _____

Number and Street City Zip

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

I heat my home mainly with { } gas { } electricity

I air-condition my home mainly with { } gas { } electricity

I certify that the above information is correct. I agree to let MID enter my home during reasonable hours to verify this information. I understand that if I refuse to let MID verify this information, I will lose my Standard Medical Baseline Quantity.

I understand that this declaration is valid for two years starting the date shown below. MID may review the declaration annually and after two years either (1) allow it to remain in effect beyond that 2-year period or (2) notify me that I must fill out a new declaration.

Customer Signature _____ Date _____

The Standard Medical Baseline Quantity is 16.438 kilowatt-hours (kwh) of electricity per day year round. If these quantities do not meet your need, please call MID at 209-722-3041 to inquire about additional Medical Baseline Quantities.

Please notify MID immediately if the person qualifying for Medical Baseline Quantities moves to another address or you no longer need the additional allowance.

TO BE COMPLETED BY A LICENSED PHYSICIAN OR A PERSON LICENSED PURSUANT TO THE OSTEOPATHIC INITIATIVE ACT.

I certify that the medical condition and needs of _____, who is a full time resident of the customer household.

1 Requires use of a life-support device Yes _____ No _____

(A life-support device is any medical device used to sustain life or relied upon for mobility. To qualify for a Medical Baseline Quantity this device must be used in the home and must run on gas or electricity supplied by MID. The term "life-support device" includes, but is not limited to, respirators, iron lungs, hemodialysis machines, suction machines, electric nerve stimulators, pressure pads and pumps, aerosol tents, electrostatic and ultrasonic nebulizers, compressors, IPPB machines, and motorized wheelchairs. Devices used for therapy rather than for life support generally do not qualify).

2 The following life-support device(s) is/are used in the above named patient's home (please indicate whether electricity is used to operate the device(s):

_____ [] electricity
 _____ [] electricity
 _____ [] electricity

3 Requires extra heating and/or cooling for one of the following:

Paraplegic	Yes _____	No _____
Quadriplegic	Yes _____	No _____
Hemiplegic	Yes _____	No _____
Multiple Sclerosis	Yes _____	No _____
Scleroderma (heating only)	Yes _____	No _____

Other (please explain)

If condition above is "Other", is the special need for heating or air-conditioning essential to sustain the patient's life?

Yes _____ No _____ (one of these two boxes must be checked)

4 Is being treated for a compromised immune system or life threatening illness.

If you answered yes to question 3 above, is the special need for heating or air-conditioning medically necessary to sustain the life of the person or prevent deterioration of the person's medical condition ?

Yes _____ No _____

Doctor's Name _____ Phone No. (_____) _____
 (please print or type)

Office address _____
 (street, city, and zip code)

MD / DO California State License Number _____

Signature of Doctor _____ Date _____