MERCED IRRIGATION DISTRICT
WATER & POWER

Declaration of Eligibility for a Standard Medical Baseline Quantity

HOW TO APPLY:

CUSTOMER: Complete Account Information, Patient Information, sign Agreement section (Page 1) and forward to Doctor to complete Page 2.

DOCTOR: Complete and sign the Statement of Certification sections (Page 2). Completed application **MUST** be returned from the Doctor's office via fax to MID at (209) 354-2876.

Please call Customer Service at (209) 722-3041 with any questions regarding completion of this application.

ACCOUNT INFORMATION

Customer Name (as it appears on your MID bill)		
Service Address		
City	Zip Code	
Home Phone	Work Phone	MID Account Number

PATIENT INFORMATION

Patient Name	Patient Date of Birth	Relationship to Customer

1. Life Support Device Definition: A life-support device is any medical device necessary to sustain life or relied upon mobility. To qualify under this rule, the device must be used in the home and must operate on electricity supplied by the DISTRICT. The term "life-support device" includes, but is not limited to, respirators, iron lungs, hem dialysis 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. Equipment must be plugged in and not battery operated)

   Type of life support device(s) used: _____

2. Special Space Conditioning: Special space conditioning refers to the use of air conditioning and/or electric heating to maintain a specific room temperature which is essential to sustain the life of a resident with a medical condition such as cystic fibrosis, multiple sclerosis or other medical condition deemed by a Doctor to require special space conditioning. Your main source of energy for heating or air conditioning must be supplied by the DISTRICT.

   Reason for special space conditioning: _____

AGREEMENT

1. I, the undersigned customer of the Merced Irrigation District, hereby claim eligibility and make application for a medical rate assistance discount. The device described above is used in my residence by the above patient and is an essential life support device powered by electricity supplied by the District.
2. I understand that this agreement does not guarantee a continuous supply of electricity and that I should provide an alternative source of electricity, if needed in case of power outages.
3. I hereby grant right of access to my residence during regular business hours to the District for verification of information given on this application if necessary. I understand that refusal of access for this purpose will be considered just cause for denial of the discount. I agree to promptly notify the District at the termination of use of the life support device or of equipment changes. A new application and/or doctor's certification may be required when there is a change of address. Applications for this discount will be subject to approval by the District and will be subject to bi-annual review.

   All information given on this application is true to the best of my knowledge. I understand that any misinformation could lead to disqualification for the medical rate assistance program.

   Signature: _____ Date: _____

STATEMENT OF CERTIFICATION
To be completed by a Medical Doctor or Osteopath licensed to practice medicine

Patient Name	Patient Date of Birth

Life Support Device

☐ **Yes**	☐ **No**	IPPB (Intermittent Positive Pressure Breathing)
☐ **Yes**	☐ **No**	Oxygen Concentrator
☐ **Yes**	☐ **No**	Electric Wheelchair
☐ **Yes**	☐ **No**	In-Home Dialysis Cycler
☐ **Yes**	☐ **No**	Other Equipment (description):

Special Heating and Cooling Needs

Medical discount is available for special heating and/or cooling needs if the patient is:

☐ Parapalegic ☐ Quadriplegic ☐ Hemiplegic ☐ Multiple Sclerosis ☐ Scleroderma

Heating or cooling is medically necessary to sustain the person's life or prevent deterioration of the person's medical condition:

☐ **Yes**	☐ **No**	Special Cooling Needs (description):
☐ **Yes**	☐ **No**	Special Electric Heating Needs (description):

Physician Certification (MD or DO)

Diagnosis/Medical Condition

I certify that the life support device(s) and/or additional heating or cooling will be required for a minimum of 12 months. Duration of medical condition:

☐ Number of Years _____ ☐ Permanent

☐ **Yes**	☐ **No**	Does Interruption in power cause a potentially life-threatening medical condition?

Doctor's Name	Phone Number
Office Address	City, State Zip Code
California Medical License Number	Fax Number
Doctor's Signature	Date

MID Use Only		
☐ Approved ☐ Not Approved	CS Staff Signature	Date
Reason for Disqualification:	☐ Heating/Cooling needs do not qualify ☐ Application Incomplete ☐ Equipment does not qualify	