Application for Chronic Condition or Critical Care Residential Customer Status

IMPORTANT INFORMATION

- **This form will not be processed if incomplete, unreadable, or improperly submitted.** All information is required, unless otherwise indicated.
- **Submission of this application does not automatically result in chronic condition or critical care status.** Notification of the action taken with regard to this form will be provided to the customer at the mailing address provided.
- Designation as a chronic condition or critical care residential customer does not relieve a customer of the obligation to pay for electric service, and service may be disconnected for failure to pay.
- **Chronic condition or critical care status does not guarantee an uninterrupted, regular, or continuous power supply. If electricity is a necessity, you must make other arrangements for on-site back-up capabilities or other alternatives in the event of loss of electric service.**
- This qualification requires renewal one year from the date you are qualified. The information on this form may be subject to verification and additional information may be required from you or your physician.
- For questions about this form, contact the Customer Care Center during normal business hours at 512-930-3640 or customercare@georgetown.org.

INSTRUCTIONS:

- **Customer:** Complete Part 1 of the APPLICATION, and provide to patient's physician for completion. **This application will not be processed unless submitted by the physician to Georgetown Utility Systems.**

- **Physician:** After completing Part 2 of the following page, please forward the APPLICATION to the Customer Care Center:

  Email: customercare@georgetown.org
  Fax: 512-930-3534

APPLICATION for Chronic Condition or Critical Care Residential Customer Status

All information is required.			
PART 1 – TO BE COMPLETED BY THE CUSTOMER			
Customer Name (person's name on electric account)			
Service Address (found on your electric bill)		**City, State ZIP**	
Mailing Address (if different than Service Address)		**City, State ZIP**	
Primary Phone Number		**Other Phone Number (if any)**	
Secondary Contact Name (Person you are designating to be contacted about your electric service.)			
Primary Phone Number		**Other Phone Number (if any)**	

I have read and understood the preceding information and certify that the information provided in this form is correct. I understand the information may also be used to determine whether I am eligible for additional notices and other protections relating to my electric service and may be used to provide notices relating to my electric service to the person listed as the secondary contact.

Customer Signature **Date**

Patient's Name

(Person, **residing permanently at the above Service Address,** for whom critical care or chronic condition status is being sought).

I have read and understood the preceding information and certify that the information provided in this form about me (or the patient) is correct. I consent to the release of the information in this form concerning my (or the patient's) medical condition for the purposes stated in this form and in processing this form.

Patient/ Patient's Guardian, Parent, or Managing Conservator Signature **Date**

PART 2 – TO BE COMPLETED BY THE PATIENT'S PHYSICIAN

PART 2A	**YES**	**NO**
Is the patient dependent upon an electric-powered medical device **to sustain life**?		
Does the patient have a serious medical condition that requires an electric-powered medical device or electric heating or cooling to prevent impairment of a major life function through a significant deterioration or exacerbation of the person's medical condition?		
Does the patient require on-site back-up capabilities or other alternatives for loss of normal electrical service?		
How long can the patient sustain without electrical service? (number of hours)		
Type of Electric, Life Sustaining Equipment Used:		

PART 2B			
Physician Name (printed)		**Texas Medical Board License Number**	
Telephone Number		**Fax Number**	
Physician Signature		**Date**	