



Hercules Municipal Utility
 111 Civic Drive
 Hercules CA 94547

Utility Account Holder Name: _____ Phone Number _____

Social Security Number: _____ Utility Account Number: _____

Mailing Address: _____

Patient name and relationship _____

Type of equipment required by the patient- please include make, model, and voltage information:

Make:	Model:
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Program Requirements:

- *Patient must reside in the residence receiving electric service.*
- *To be eligible for an electric rate discount, an essential medical support device is defined as any medical device requiring utility-supplied electrical energy for its operation and which is required to support the life of a person residing in a residential dwelling in accordance with Municipal Code Section 14.24.077C.*

A "medical support device" is defined as any medical device requiring utility-supplied electrical energy for its operation and which is regularly required to support the life of a person residing in a residential dwelling, including respirators, iron lungs, hemodialysis machines, suction machines, pressure pads and pumps, electro-static and ultrasonic nebulizers, IPPB machines, electric nerve stimulators, aerosol tents, compressors and motorized wheelchairs. A "medical support device" shall also include electric heating or air conditioning for paraplegic, hemiplegic and quadriplegic persons and electric heat or air conditioning for persons with multiple sclerosis.

- *To qualify, your household's total taxable income is no greater than that shown on the chart¹ below*

NUMBER OF PERSONS IN HOUSEHOLD

INCOME CATEGORY	1	2	3	4	5	6	7	8
LOWER INCOME	46,350	53,000	59,600	66,250	71,550	76,850	82,150	87,450

Required Proof of Income:

- A tax return transcript for every household member excluding students 18 years and younger. To obtain a free tax return transcript, call the IRS at 1-800-829-1040 or go online at www.irs.gov.

AGREEMENT: I certify, under penalty of perjury, that the above information indicated by me is true and correct. I also understand that the above information is subject to annual verification and I agree to provide such verification or be denied the discount. I understand that, if approved, my discount is limited to an additional 500 kilowatt hours (kWh) used monthly at the lowest tier price. I understand it is my responsibility to notify the Hercules Municipal Utility when the person using the medical equipment either no longer uses the device or no longer resides at this location.

Singed: _____ Date: _____

¹ Figures released for 2005 U.S. Dept. of Housing & Urban Development as "Lower Income" for Contra Costa County guidelines may change annually.

Statement of Certification Must Be Completed*
By Medical Doctor or Osteopath Licensed to Practice Medicine
In the State of California

1. Patient's Name: _____
2. What is the patient's diagnosis? _____
3. Type of equipment required by the patient (please include make, model information):

4. For certain disabled persons requiring energy for special electric heat or air conditioning needs, please complete:
 Paraplegic, hemiplegic or quadriplegic requiring special heat and/or air conditioning.
 Multiple sclerosis patient requiring special electric heat and/or air conditioning.
5. To be eligible for a rate discount, an essential medical support device is defined as any medical device requiring utility-supplied electrical energy for its operation and which **is required to support the life** of a person residing in a residential dwelling. In your opinion, does the equipment described above meet this requirement?
 Yes No
6. How many _____ hours _____ minutes can the patient cope without electricity before a life-threatening medical condition arises?
7. How long will the patient be required to use such equipment?
 Less than 1 year 1-2 years Life-time Other _____
8. Can the electrically-powered equipment be operated by an auxiliary source such as a hand pump (crank) or battery?
 Yes No

I hereby certify that this patient regularly requires the use of the above life saving medical equipment that is powered by electricity:

Doctor's Signature: _____ Print Name: _____

California Medical License No. _____

Telephone Number: _____

Address: _____

Street

City

State

Zip

*This certification must be completed by Doctor or application will not be accepted.

Hercules Municipal Utility Use Only

Account Number: _____

Effective Date: _____

Approval: Yes / No

Authorized By: _____

Return this form to:

Hercules Municipal Utility

111 Civic Drive

Hercules CA 94547

For information call (510)799-8200