



APPLICATION FOR MEDICAL EQUIPMENT DISCOUNT (MED) RATE (Formerly: Application for Life Support Rate)

INSTRUCTIONS:

1. Please print all information legibly.
2. Please have your doctor complete the reverse side.
3. **Mail completed application to:
Sacramento Municipal Utility District
Credit Division, Mail Stop A253
P.O. Box 15830
Sacramento, CA 95852-1830**

Qualification for the MED Rate requires that the customer:

1. be currently served under residential rates, and
2. provide a certification by a doctor of medicine or an osteopath licensed to practice medicine in the State of California establishing that a particular device or a medical condition as described below is necessary to sustain the resident's life.

The person qualifying for this rate must be a full time resident of the household.

CUSTOMER INFORMATION	FIRST	INITIAL	LAST	SOCIAL SECURITY NO.
SERVICE ADDRESS	NUMBER	STREET		APT. NO.
	CITY			ZIP CODE
IF DIFFERENT MAILING ADDRESS	NUMBER	STREET		APT. NO.
	CITY			ZIP CODE
HOME PHONE ()	WORK PHONE ()	SMUD ACCOUNT NO. (IF KNOWN)	PATIENT'S RELATIONSHIP TO CUSTOMER	
PATIENT'S NAME		PATIENT'S AGE	IF APPLICABLE, ADDRESS OF MOBILE HOME PARK:	
DATE OF BIRTH	INSURANCE /MEDICAL NUMBER			

Medical Equipment Device:

Medical equipment, for purposes of the MED Rate, is defined as any medical device requiring utility-supplied energy for its operation that is regularly required to sustain the life of a person residing in a residential dwelling. The term "medical equipment" 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. It also includes electric heat or air conditioning for paraplegic, hemiplegic, or quadriplegic persons and multiple sclerosis patients.

Type of medical equipment used:

AGREEMENT

I, the undersigned, as a customer of the Sacramento Municipal Utility District, hereby claim eligibility and make application for the electric rate discount for medical equipment within home usage. The device described above is used in my home and is essential medical equipment powered by electricity supplied by the Sacramento Municipal Utility District.

I hereby grant right of access to my residence during regular business hours to the Sacramento Municipal Utility 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 rate discount. I agree to notify the Sacramento Municipal Utility District at the immediate termination of use of the medical equipment, or any medical apparatus change. A new application and/or doctor's certification may be required when there is a change of address. Applications for this rate will be subject to approval by the District and will be subject to 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 MED Rate. My signature gives consent for this information to be shared with other offices of the Federal, State, County Governments, with my utility company, and with other utilities or their agents to enroll me in their assistance programs.

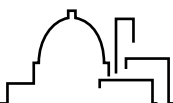
Signature of Applicant

Date

Customer Services 1-888-742-SMUD (7683)



SACRAMENTO MUNICIPAL UTILITY DISTRICT
6201 S Street, P.O. Box 15830, Sacramento, CA 95852-1830
The Power To Do More.®



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**STATEMENT OF CERTIFICATION
By Medical Doctor or Osteopath Licensed to Practice Medicine
in The State of California**

PLEASE PRINT ALL INFORMATION LEGIBLY

1. Patient's Name
2. What is the patient's diagnosis?
3. Type of equipment required by the patient <i>(be specific)</i>
4. For certain disabled persons requiring SMUD supplied energy for special electric heat or air conditioning needs please complete: <input type="checkbox"/> paraplegic, hemiplegic, or quadriplegic person requires special electric heating. <input type="checkbox"/> Multiple Sclerosis patient requires special electric heat and/or air conditioning.
5. To be eligible for a rate discount, essential medical equipment is defined as any medical device requiring utility supplied electricity for its operation that is regularly required to sustain the life of a person or relied upon for mobility. In your opinion, does the above-described equipment meet this criteria? <input type="checkbox"/> YES <input type="checkbox"/> NO
6. How long can the patient cope without electricity before a life-threatening medical condition arises? _____ Hours _____ Minutes
7. How long will the patient be required to use such equipment? <input type="checkbox"/> 0-1 year <input type="checkbox"/> 1-2 years <input type="checkbox"/> life-time <input type="checkbox"/> other _____
8. Can the electrically powered equipment be operated by an auxiliary source such as a hand pump (crank) or battery? <input type="checkbox"/> YES* <input type="checkbox"/> NO * If yes, how long a period? _____

I hereby certify that this patient regularly requires the use of the above equipment which is powered by electricity.

DOCTOR'S NAME	CALIFORNIA MEDICAL LICENSE NO.
ADDRESS	CITY ZIP CODE
TELEPHONE NO. ()	SIGNATURE OF DOCTOR DATE

SMUD USE ONLY	
ACCOUNT NUMBER	EFFECTIVE DATE
APPROVAL ACTION <input type="checkbox"/> YES <input type="checkbox"/> NO*	*COMMENTS <input type="checkbox"/> DIAGNOSIS/EQUIPMENT DOES NOT QUALIFY <input type="checkbox"/> OTHER: _____
<input type="checkbox"/> ACLM	AUTHORIZED SIGNATURE DATE
	COMPLETED BY DATE