Application for Medical Equipment Discount (MED) Rate

1. Customer information

Last name _____ First name _____

Service address _____

City _____ State _____ Zip _____

SMUD account number (found on paper bill and/or online)
(Or name of mobile home park if your electricity is submetered) _____

Download and print application at smud.org/MED

Mail completed application to:

Sacramento Municipal Utility District
MED Rate, Mail Stop A104
P.O. Box 15830
Sacramento, CA 95852-0830

2. Mailing address

House number _____ Street name _____ Unit number _____

City _____ State _____ Zip _____

3. Declaration and signature

- I certify and declare that the information I have provided for this application is true and correct, and contains no material omissions of fact to the best of my knowledge and belief.
- I certify that the patient named in step 4 below is a full time resident of this household and is dependent on a qualifying medical equipment device used in the home or has a medical condition with special electric heating or air conditioning needs.
- The medical equipment device identified on Step 4 is used in my home and is essential medical equipment powered by electricity supplied by SMUD.
- I permit the proper change to my rate schedule and consent to annual eligibility verification.
- I understand that SMUD cannot guarantee uninterrupted electricity service and I am responsible for making alternate arrangements in the event of a disruption in service.

Customer signature _____ Date _____

***If the MED Rate discount does not meet the electricity needs related to your medical condition or the medical device that you are using, please email MedicalDiscount@smud.org or call 1-888-742-SMUD** (7683).*

STOP

Please have the back of this application completed and signed by your Qualified Medical Professional. Applications submitted without signatures will be returned.

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Application for Medical Equipment Discount *(continued)*

4. Medical equipment *To be completed by qualified health professional ONLY*

This section must be completed by a doctor of medicine, nurse practitioner, family nurse practitioner or physician's assistant licensed to practice medicine.

Qualified list of medical equipment device operated on a regular basis or etraordinary electricity needs.

Patient: _____ requires the use of the following* (*Check Yes or No for each*) :

Electric wheelchair	☐ Yes	☐ No	Ventilator*	☐ Yes	☐ No
In-home dialysis cycler	☐ Yes	☐ No	Extraordinary heating needs	☐ Yes	☐ No
Oxygen concentrator*	☐ Yes	☐ No	Extraordinary cooling needs	☐ Yes	☐ No

**CPAP/BIPAP machines are not qualifying devices.*

Qualified health professional's name

Office street address

Phone number

City

State

Zip

Declaration and signature

- I certify that the medical device(s) indicated above are required for this patient.

Qualified health professional's signature

Date

License number

State

☐ Please check box if medical device(s) indicated above are required **permanently** for this patient.

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