Lubbock Power & Light

The power is yours.

Application for Chronic Condition or Critical Care Residential Customer Status

IMPORTANT INFORMATION

- This Application must be completed in order to obtain the designation of Critical Care of Chronic Condition Status.
- **This Application will not be processed and approved if incomplete, unreadable, or improperly submitted.** All information is required, unless otherwise indicated.
- For questions about this Application, please contact Customer Service at (806) 775-2509 during normal business hours.
- **Submission of this application does not automatically result in chronic condition or critical care status.** Notification of the status granted will be provided to the customer at the mailing address provided.
- Pursuant to the rules of the Public Utility Commission of Texas, 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 lives depend on an uninterrupted source of electricity, it is critical that alternate sources are available. Customer should also have a back-up plan in case power is unable to be restored quickly.**

INSTRUCTIONS:

- **Customer:** Complete PAGE 2 of this application, and provide to patient's physician for completion. **This application will not be approved unless submitted by fax or email by the physician.**
- **Physician:** After completing **PAGE 3** of the following pages, please forward only PAGES 2 AND 3 to Lubbock Power & Light by emailing LPLCustomerCare@mylubbock.us or faxing to (806) 775-3722.

PAGE 2 – To Be Completed by the Customer

PART 1: ALL INFORMATION IS REQUIRED

Customer Name:
(Name on electric account)

Patient's Name: **Is Patient a Minor (Y/N):**

(Name of Patient, who is living permanently at the Service Address, and who needs critical care or chronic condition status. The Patient may be the same person as the Customer.)

Service Address *(found on your electric bill)*

City: **State:** **ZIP:**

Mailing Address *(if different than Service Address)*

City: **State:** **ZIP:**

Account Number *(found on your electric bill)*

Customer Primary Phone:	**Customer Alternate Phone:** (if any)

Emergency (Secondary) Contact Information ***(Your application will be rejected unless you include an emergency contact name or insert "I choose not to provide an emergency contact name". Failure to include an emergency contact may result in disconnection of your electric service without notice if we are unable to contact you and your electric bill is overdue.)***

Name of Emergency Contact:

Mailing Address:

City: **State:** **ZIP:**

Phone:	**Alternate Phone (if any):**

Customer:

I have read and understood the information and certify that the information provided on this Application 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 available under Public Utility Commission rules, and may be used to provide notices relating to my electric service to the Emergency Contact.

Signature: **Date:**

Patient/ Patient's Guardian, Parent, or Managing Conservator:

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

Signature: **Relationship:** **Date:**
(Signature required, even if same person as Customer.)

PAGE 3 – To Be Completed by the Patient's Physician

FROM PAGE 2:	
PATIENT'S NAME:	
CUSTOMER NAME:	ACCOUNT NUMBER:

PART 2: ALL INFORMATION IS REQUIRED

Option #1	**YES**	**NO**
1) The patient is dependent upon an electric-powered medical device **to sustain life**.		

-AND/OR-

Option #2	**YES**	**NO**
2) The patient has 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.		
a) If yes to # 2 above, has the above medical condition been diagnosed as a life-long condition?		

Physician Name: (printed)	
Texas Medical Board License Number:	
Phone:	**Fax:**
Physician Signature:	**Date:**

After completing the Application, please forward a faxed or electronic copy of the completed and signed application to the Customer's utility indicated in part 1 on page 2. See page 1 for utility fax and email addresses.