GARLAND

Application for Chronic Condition or Critical Care Residential Customer Status

☐ **Applying for the first time**

☐ **Renewing existing status** ***PLEASE PRINT RESPONSES***

Section 1: To be completed by the Patient

Patient's name: _____ Birthdate: _____

Relationship to Customer of Record (Account holder) ☐ Self ☐ Other: _____

Home/Cell: (_____)_____ Work: (_____)_____

I hereby authorize my health care provider(s) to release the medical information included on this Application to my utility, or third parties authorized by the utility, to assist with the review, approval, and processing of this request. I understand that continuous utility service is not guaranteed and it is my responsibility to maintain a backup system or have an alternative plan in the event of a loss of utility service. I certify that the patient lives at the address listed below and that all information provided is accurate. If I meet the conditions for a Chronic Condition or Critical Care status, I also agree to notify the City of Garland in writing when this medical status is no longer necessary.

Signature: _____ Date: _____
Patient/Legal Guardian/Power of Attorney

Section 2: To be completed by the Customer of Record (Account Holder)

Customer Name on the utility account: _____

Service Address: _____

City: _____ State: _____ Zip Code: _____

Home/Cell: (_____)_____ Work: (_____)_____

Home Email: _____ Account Number: _____

Utility services provided by City of Garland: ☐ Electric ☐ Water

Please read and initial the following:

_____ **Customer understands that he/she secures no special right to preferential service and that the City of Garland in no way guarantees uninterrupted utility service(s).**

_____ **Customer understands that it is important that he/she make alternative arrangements in the event of an interruption in the normal supply of utility services.**

I certify the information above is accurate AND the patient is the customer of record or a household member of the customer of record residing at this address.

Customer Signature: _____ Date: _____

Customer should call 911 in the event of an emergency.

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Section 3: THE FOLLOWING INFORMATION IS TO BE COMPLETED BY THE PHYSICIAN OR PUBLIC HEALTH OFFICIAL ONLY.

Please Check the appropriate boxes to indicate the patient's status (Chronic Condition or Critical Care) and specify the needed utility service(s).

☐ **Chronic Condition Patient**
*Patient suffers from an existing medical condition that will be **aggravated by the lack of utility service**.*

I certify that the patient has the following Chronic Condition condition(s) that will be aggravated by the loss of utility service.

Specify the needed utility service(s): ☐ Electric ☐ Water

Condition(s): _____

Equipment: _____

Time Period: _____

☐ **Critical Care Patient**
*Patient uses life-supporting medical equipment at home and lack of the utility service would be **immediately life threatening**.*

I certify that the following life-support system(s) or medical equipment is/are used by the Critical Care patient.

Specify the needed utility service(s): ☐ Electric ☐ Water

Equipment: _____

Life support equipment requirements: _____

Other information or comments: _____

_____

Check one: ☐ **Physician** ☐ **Public Health Official** **License #:** _____

Physician/Health Official name *(PLEASE PRINT)*: _____

Name and Job title (if not a physician): _____

Business address: _____

Business phone: (_____)_____ **Fax:** (_____)_____

I certify that the patient identified on this form has been examined by me, to the best of my knowledge the information provided is true, and the patient meets the criteria of a Chronic Condition Patient or a Critical Care Patient.

Signature: _____ **Date:** _____
(Physician or Public Health Official)

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DOCUMENT VALID FOR 12 MONTHS FROM DATE SIGNED ABOVE.

Return completed form to: **Utility Customer Service**
City of Garland
217 N. Fifth St.
Garland, TX 75040