



City of Caldwell

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 or Chronic Condition Status with your utility.
- **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, call the Utilities Department at 979-567-3271 ext. 100 or 101.
- **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.
- 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 electricity is a necessity, you must make other arrangements for on-site back-up capabilities or other alternatives in the event of loss of electric service.**

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 mail or email by the physician to the applicable Utilities Department:

114 S. Echols St. Caldwell, TX 77836

utilitybilling@caldwelltx.gov

- **Physician:** After completing PAGE 3 of the following pages, please forward only PAGES 2 and 3 to the City of Caldwell Utilities Department indicated on the form (using the mailing or email address listed above).
- Physician may submit a letter in lieu of the form on Page 3, but it must be attached to Page 2.

PART 1: ALL INFORMATION IS REQUIRED

Customer Name:

(Name on electric account)

Patient's Name:

(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 billl)

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 Contact Information (Failure to include an emergency contact may result in disconnection of your electric service without notice if the City is 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:

(Signature required, even if same person as Customer.)

Date:

PART 2: ALL INFORMATION IS REQUIRED

Option #1	YES	NO
The patient is dependent upon an electric-powered medical device <u>to sustain life.</u>		

-AND/OR-

Option #2	YES	NO
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.		
If yes to the above question, 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 mailed 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 mailing and email addresses.