MEDICAL-LEGAL PARTNERSHIP:
COMPLETING FORMS FOR PATIENTS WITH HIV

Law Project of Pennsylvania

a non-profit, public interest law firm

1211 Chestnut Street, Suite 600
Philadelphia, PA 19107
(215) 587-9377
www.aidslawpa.org

AIDS LAW PROJECT OF PENNSYLVANIA
MEDICAL-LEGAL PARTNERSHIP: COMPLETING FORMS FOR PATIENTS WITH HIV
TABLE OF CONTENTS

I. TANF and GA Work Requirement Exemptions

A. Disability
B. Caring for a Disabled Family Member
C. Domestic Violence
D. Parents of Young Children

II. Medical Certification to Prevent Utilities Shut Off

A. PGW
B. PECO
C. Water Revenue Bureau

III. Bureau of Professional and Occupational Affairs Policy Statement Interpreting the Term "Infectious, Communicable or Contagious Disease"

TANF and GA Work Requirement Exemptions

TANF and GA Work Requirement Exemptions

Disability

If a client is unable to participate in RESET (fully or partially, temporarily or permanently) because of a disability, the form used depends on whether he or she is receiving GA or TANF.

For **TANF** recipients, use form **PA 635, Medical Assessment Form.**

For **GA** recipients, use form **PA 1663, Employability Assessment Form.**

Caring for a Disabled Family Member

Form PA 1820, Caregiver Review Form, is used to assert that a client cannot participate in RESET because he or she cares for a disabled family member. It must be completed and signed by the caregiver and the disabled person's medical provider.

Domestic Violence

TANF and GA work requirements can be waived due to domestic violence. Use Form PA 1747, Domestic Violence Verification Form, to request exemption.

It is important to note when completing the form that if a client verifies domestic violence by filling out block 4, self-affirmation, he or she will have to resubmit the form every six months as continued proof that fulfilling the program requirements would increase the risk of domestic violence.

However, if blocks 2 or 3 are used, a client will not have to submit any other information to prove that the risk of further domestic violence continues. For this reason, if possible, a third party should complete blocks 2 or 3.

Parents of Young Children

There is no dedicated form to show that a parent should be exempt from RESET because they are caring for a young child. The relevant sections of the DPW Cash Assistance Handbook regarding exemptions for parents of young children are included. A simple letter, informed by the DPW Handbook guidelines, is sufficient for requesting an exemption from RESET.

A full list of reasons for exemption from work requirements is located in DPW Cash Assistance Handbook sections 135.2 and 135.3.

COUNTY ASSISTANCE OFFICE NAME AND ADDRESS	
Return To CAO By:	CAO Fax Number:

CASE IDENTIFICATION				
CO	RECORD NUMBER	CAT	CSLD	DIST
RECORD NAME				DATE

Commonwealth of Pennsylvania Department of Public Welfare

MEDICAL ASSESSMENT FORM

This Medical Assessment Form (PA 635) is needed to determine whether an individual is able to participate in employment and training activities, what treatment plan(s) could help the individual move towards employment, or determine if the individual is a good candidate for disability benefits or is pregnant.

COMPLETED BY COUNTY ASSISTANCE OFFICE

Client's Name	Client's Date of Birth	Client's Phone Number
Client's Address *(Street, City, Zip Code)*		

Instructions to Medical Provider

This form may be completed by a counselor, social worker, or mental health therapist, but must be agreed upon and signed by a physician, psychologist, physician assistant or certified registered nurse practitioner.

Please complete the appropriate section(s) of this form and return (fax or mail) to the county assistance office (above) by ____________.

Confirmation of Pregnancy

If this individual is pregnant, give expected delivery date. _____/_____/_____

NOTE: IF PREGNANCY DOES NOT AFFECT THIS INDIVIDUAL'S ABILITY TO WORK, ONLY COMPLETE SECTION I OF THIS FORM.

SECTION I MEDICAL PROVIDER INFORMATION Please complete this entire section.

Printed Name of Medical Provider: ______________________________

Medical License Number: ______________________ NPI Number: ______________ (If Applicable)

Phone Number (   ): ______________________

Address: ______________________

____

____

I certify that all of the information provided on this form is true, correct and complete to the best of my professional knowledge. I further certify that, the diagnosis and assessment related to this client's health condition are based on his/her medical condition as determined by examination and knowledge of this client's medical history.

I understand and agree that the diagnosis and supporting documentation may be subject to review by the Department of Public Welfare's Medical Review Team.

Signature of medical provider must be original or the form is invalid. Rubber stamps, labels or other reproductions are not acceptable.

______________________________ ______________

______________________________ ______________

SECTION II EMPLOYABILITY

IF CHECKBOX 1 IS SELECTED FOR THIS INDIVIDUAL, DO NOT COMPLETE SECTION III.

IF EMPLOYABLE, THIS INDIVIDUAL WILL HAVE THE REQUIREMENT TO WORK OR PARTICIPATE IN TRAINING FOR ______ HOURS PER WEEK. PLEASE SELECT ONE OF THE FOLLOWING BASED ON YOUR BEST ESTIMATE OF THE INDIVIDUAL'S CURRENT CAPABILITIES:

1. ☐ **EMPLOYABLE –**

This individual is able to work or participate in training, on a sustained basis, for the hours that are required per week (see above).

☐ with the following reasonable accommodations: ____

____

2. ☐ **LIMITED EMPLOYABILITY – Please check all that apply. Please also complete Section III.**

This individual is able to work or participate in training, on a sustained basis, for fewer than the hours that are required per week (see above). Approximately how many hours can the individual participate per week? ____________

☐ With the following reasonable accommodations

____

____

What is the recommended treatment plan to remediate this condition so this individual is able to work or participate in training, on a sustained basis, for the hours that are required per week (see above) or to increase the hours of participation?

☐ Prescribed Medication

☐ Therapy: ________ hours per week Type: ______________________________________

☐ Follow-up with specialist: Specialty ______________________ Name of Physician______________________

Referral Made for Patient? __________

☐ Other (describe): ____

This individual is expected to be limited from being able to work or participate in training for the number of hours indicated above on a sustained basis, until ____ / ____ / ______.

3. ☐ **TEMPORARY INCAPACITY – Please also complete Section III.**

This individual's physical or mental condition precludes him/her from participating in any form of employment or training activity, on a sustained basis, at this time, but the condition is expected to improve within 12 months.

This individual's temporary incapacity is expected to prevent working or participation in training until ____/____/______.

What is the recommended treatment plan to remediate this condition so this individual is able to work or participate in training, on a sustained basis, for the hours that are required per week (see above) or to increase the hours of participation?

☐ Prescribed Medication

☐ Therapy: ________ hours per week Type: ______________________________________

☐ Follow-up with specialist: Specialty ______________________ Name of Physician______________________

Referral Made for Patient? __________

☐ Other *(describe)*: ____

4. ☐ **DISABLED – Please also complete Section III.**

This individual has a physical or mental condition that is expected to last for 12 months or more, and precludes any form of employment, on a sustained basis, of at least 30 hours per week. The individual is a candidate for Social Security Disability or Supplemental Security Income.

The disability begin date _____/_____/_____.

SECTION III DIAGNOSIS (ES)

Include name of each Diagnosis with ICD-9 code and description. Please explain how each diagnosis affects the client's ability to work.

Primary Diagnosis:

Secondary Diagnosis:

Tertiary Diagnosis:

Other Diagnosis:

The individual is following the prescribed treatment plan.

_____ Yes _____ No _____Don't Know If No, indicate:

- ☐ Not taking medication as prescribed
- ☐ Not following up with specialist
- ☐ Not eligible or appropriate for needed medication or treatment. Explain: ____________
- ☐ Other (describe): ____________

PLEASE READ INSTRUCTIONS BEFORE COMPLETING FORM

COMPLETION INSTRUCTIONS - EMPLOYABILITY ASSESSMENT FORM (PA 1663)

An individual with a physical or mental disability which temporarily or permanently precludes him or her from any gainful employment may be eligible for General Assistance, GA. This form must be completed to document the disability.

To implement these requirements, we are asking you to complete this form for an applicant for public assistance.

Who may complete assessment: The assessment may be performed only by a licensed physician, physician's assistant, certified registered nurse practitioner, or psychologist.

Who signs the form: Only the individual who performed the employability assessment may sign the form. The signature must be original or the form will be invalidated. Signature or clinic stamps, labels, and other facsimilies ***are not*** acceptable.

General form completion requirements: The information on the form and attachments must be complete and legible. The inability of county staff to read your material will result in the client's application being delayed and the form being returned to you for clarification. If possible, the form and any attachments should be typed.

If all questions are not answered fully, the client's application will be delayed and the form returned to you for completion.

EMPLOYABILITY SECTION

Permanently Disabled: Check this block if the client should be considered permanently disabled and, therefore, unable to work. When making this determination, you must consider whether the client is unable to engage in ***any gainful employment*** by reason of any medically determinable physical or mental impairments. A medically determinable physical or mental impairment is an impairment that results from anatomical, physiological, or psychological abnormalities which can be shown by medically acceptable clinical and laboratory diagnostic techniques. A physical or mental impairment must be established by medical evidence consisting of signs, symptoms, and laboratory findings, ***not*** only by the individual's statement of symptoms.

Temporarily Disabled: There are two blocks for use in evaluating a client who is ***temporarily disabled*** - one for a client whose disability is expected to last 12 months or more, and one for a client whose disability is expected to last less than 12 months. Check the appropriate block if the client has an injury or condition that temporarily prevents the client from working in any gainful employment. Once the injury or ailment is resolved, the client can work. The date shown is when the temporary disability is expected to end. A client whose disability is expected to last 12 or more months may be a candidate for Social Security Disability or SSI benefits.

Employable: Check this block if, based on your examination, it is not appropriate to check either the Permanently or Temporarily Disabled blocks.

EXAMINATION RESULTS SECTION

This section must be fully completed so that it clearly establishes the basis for your decision that the client is either temporarily or permanently disabled. Simply providing a diagnosis is not sufficient. You must provide information about the ***basis*** for your diagnosis and assessment. Further, documentation sufficient to support your decision, for example medical records, X-rays, and lab reports, must be available for further review if required.

Questions: Contact your local county assistance office

CAO NAME AND ADDRESS

CASE IDENTIFICATION

CO	RECORD NUMBER	CAT	CSLD	DIST
RECORD NAME				DATE

PENNSYLVANIA DEPARTMENT OF PUBLIC WELFARE
EMPLOYABILITY ASSESSMENT FORM

WORKER:

SECTION I (Must be completed by applicant/recipient for public assistance)

PLEASE PRINT OR WRITE CLEARLY. BE SURE TO SIGN YOUR NAME AND DATE THIS FORM IN THE APPROPRIATE SPACE BELOW.

NAME:	BIRTHDATE:	SOCIAL SECURITY NO.:
ADDRESS:	TELEPHONE NUMBER:	
CITY:	STATE:	ZIP CODE:

BRIEFLY EXPLAIN WHY YOU BELIEVE YOU CANNOT WORK:

I HEREBY AUTHORIZE ALL MEDICAL PROVIDERS TO RELEASE ANY MEDICAL INFORMATION THAT IS RELATED TO MY EMPLOYABILITY TO THE PENNSYLVANIA DEPARTMENT OF PUBLIC WELFARE. THE INFORMATION OBTAINED WILL BE USED ONLY FOR PURPOSES RELATED TO AN ASSESSMENT OF MY ABILITY TO WORK AND MY ELIGIBILITY FOR PUBLIC ASSISTANCE.

X

(SIGNATURE) PUBLIC ASSISTANCE APPLICANT/RECIPIENT　　PRINT NAME　　DATE

AFTER YOU HAVE COMPLETED THIS SECTION, ARRANGE FOR AN APPOINTMENT WITH A LICENSED PHYSICIAN (MEDICAL DOCTOR OR DOCTOR OF OSTEOPATHY), PHYSICIAN'S ASSISTANT, CERTIFIED REGISTERED NURSE PRACTITIONER, OR PSYCHOLOGIST. GENERAL ASSISTANCE BENEFITS CANNOT BE AUTHORIZED FOR YOU UNTIL THE FULLY-COMPLETED FORM IS RETURNED TO THE COUNTY ASSISTANCE OFFICE WORKER.

RETURN TO:

SECTION II (To be completed by a licensed physician, physician's assistant, certified registered nurse practitioner, or psychologist)

The information on this form will be used by Department of Public Welfare, DPW, to make an assessment of your patient's qualification for GA benefits based on his or her inability to work. Please complete this section based on your evaluation of the patient's statement in Section I, your examination of the patient, and your use of other medical procedures.

EMPLOYABILITY (Check only one)

1. ☐ **PERMANENTLY DISABLED** - Has a physical or mental disability which **permanently** precludes any gainful employment. The patient is a candidate for Social Security Disability or SSI.

2. ☐ **TEMPORARILY DISABLED - 12 MONTHS OR MORE** - Is currently disabled due to a temporary condition as a result of an injury or an acute condition and the disability **temporarily** precludes any gainful employment.

   The temporary disability began ____________ (DATE) and is expected to last until ____________ (DATE).

   The patient may be a candidate for Social Security Disability or SSI benefits.

3. ☐ **TEMPORARILY DISABLED - LESS THAN 12 MONTHS** - Is currently disabled due to a temporary condition as a result of an injury or an acute condition and the disability **temporarily** precludes any gainful employment.

   The temporary disability began ____________ (DATE) and is expected to last until ____________ (DATE).

4. ☐ **EMPLOYABLE** - The patient's physical and/or mental condition is such that he or she can work.

EXAMINATION RESULTS: (Both parts of this section must be completed if **#1, #2** or **#3** above is checked. If not completed, the client will be ineligible for GA.)

1. **DIAGNOSIS (Primary and Secondary):**

   PRIMARY:

   SECONDARY:

2. **ASSESSMENT BASED UPON: (Check all that apply)**

   ☐ A. PHYSICAL EXAMINATION

   ☐ B. REVIEW OF MEDICAL RECORDS

   ☐ C. CLINICAL HISTORY

   ☐ D. APPROPRIATE TESTS AND DIAGNOSTIC PROCEDURES

   ☐ E. OTHER (Specify) ____________________

AS A LICENSED MEDICAL PROVIDER, I CERTIFY THAT I HAVE READ AND COMPLIED WITH THE ATTACHED INSTRUCTIONS AND THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY PROFESSIONAL KNOWLEDGE. I FURTHER CERTIFY THAT MY DIAGNOSIS AND ASSESSMENT ARE BASED SOLELY ON THE PATIENT'S CONDITION AS DETERMINED BY MY EXAMINATION. I UNDERSTAND AND AGREE THAT MY DIAGNOSIS AND SUPPORTING DOCUMENTATION MAY BE SUBJECT TO REVIEW BY THE DEPARTMENT OF PUBLIC WELFARE.

MEDICAL PROVIDER (PRINT NAME):	TELEPHONE NO.:
ADDRESS:	

____________________ SIGNATURE ____________________ MEDICAL ASSISTANCE PROVIDER NO. ____________ DATE

Operations Memorandum
Employment & Training
OPS090904

September 24, 2009

SUBJECT: **Implementing Caregiver Exemption**
TO: **Executive Directors**
FROM: **Joanne Glover, Director, Bureau of Operations**

Purpose

To advise CAOs that:

1. A new ETP Status Code (ETP 54) has been created to identify a TANF parent who is providing care for a disabled family member living in the home; and

2. Good Cause (GC) code 54 has been eliminated, effective July 27, 2009.

Background

In 2006, GC code 54 was created to identify a parent who cares for a disabled family member living in the home. Since implementation of GC 54, the Administration for Children and Families (ACF), Department of Health and Human Services (HHS) has made a concession to allow states to claim an exemption from the work participation rate for individuals who meet the federal definition of a work-eligible individual who is a parent caring for a disabled family member living in the home, regardless of the family member's school status.

Discussion

To simplify data entry at the CAO and to mirror the ACF-HHS policy on exemption of caregivers, DPW has created ETP 54 to identify a TANF parent who meets caregiver criteria as determined by the Caregiver Review Form (PA 1820).

The new ETP code was effective July 27, 2009. No new GC 54 may be entered after this date. ETP 54 should be reviewed at each redetermination per OPS 060802.

In implementing ETP 54:

1. The CAO will use the Caregiver Review Form to determine eligibility for ETP 54.

2. CAOs will no longer open CSPREN screen for entry of GC 54 to identify caregivers.

3. A parent who qualifies as an exempt caregiver, who voluntarily participates in an approved employment and training activity, and wishes to receive subsidized child care, must be employed or have an activity indicated on an open CAPREN/CSPREN screen.

4. At the next redetermination, caregivers who are currently identified in CIS by GC 54 must be re-evaluated for the caregiver exemption. The CSPREN screen indicating GC 54 must be closed and, if eligible for the caregiver exemption (as verified on the PA 1820), ETP 60 changed to ETP 54.

Next Steps

1. Retain this Operations Memorandum until the information is incorporated in the Cash Assistance Handbook.

2. Direct any questions to the Bureau of Employment and Training Programs at 717-787-1302.

CAREGIVER REVIEW FORM

Caregiver Name, Address and Telephone Number	County/Record Number

THIS SECTION MUST BE COMPLETED IF YOU ARE CARING FOR A FAMILY MEMBER WITH A DISABILITY		
Individual's Name	Age	Relationship To You
Does this person live with you? ☐ Yes ☐ No		
Describe (in detail) what you do for the individual with the disability:		

By signing this form, I certify that the statements above are true and correct.

_________________________ Caregiver Signature

_____________ Date

THIS SECTION MUST BE COMPLETED BY THE LICENSED MEDICAL PROVIDER TREATING THE INDIVIDUAL WITH A DISABILITY
Name, Address and Telephone Number of Medical Provider

By signing this form, I certify that the individual with disabilities needs care.

_________________________ Medical Provider Signature

_____________ Date

DOMESTIC VIOLENCE VERIFICATION FORM

NAME:	CASE NUMBER:

PLEASE READ THESE INSTRUCTIONS CAREFULLY. - ONLY ONE OF THE COLORED BLOCKS MUST BE COMPLETED. BLOCK 2 OR 3 IS USED WHEN VERIFICATION IS AVAILABLE. BLOCK 4 IS USED WHEN VERIFICATION IS NOT READILY AVAILABLE AND THE CLIENT AFFIRMS THE DOMESTIC VIOLENCE. BLOCKS 1 AND 5 ARE COMPLETED FOR ALL GOOD CAUSE BASED ON DOMESTIC VIOLENCE CLAIMANTS.

1. GOOD CAUSE CLAIM

I, ______________________, request to be excused from the following TANF program or CCIS Child Care program requirement(s) because of domestic violence: ☐ support cooperation; ☐ RESET ☐ time limit (Time-Out); ☐ time limit (Extended TANF); or ☐ other TANF or CCIS program requirement (please specify) ______________________,
I have been asked to provide verification to support my claim. I have cooperated/will cooperate in providing verification below.

2. RECORDS

I SUBMIT ONE OF THE FOLLOWING, IF AVAILABLE:

☐ LAW ENFORCEMENT RECORDS
☐ COURT RECORDS
☐ MEDICAL/TREATMENT RECORDS
☐ SOCIAL SERVICE RECORDS
☐ CHILD PROTECTIVE SERVICES RECORDS
☐ OTHER (SPECIFY) ______________________

3. AUTHORIZATION/VERIFICATION BY A THIRD PARTY

I authorize ______________________ to complete the verification below and to provide it to the Department of Public Welfare for the purpose of verifying my good cause.

______________________ DATE
______________________ CLIENT SIGNATURE

THIS STATEMENT IS SUBMITTED BY:

______________________ (NAME)
______________________ (TITLE)
______________________ (ORGANIZATIONAL AFFILIATION)
______________________ (ADDRESS)

I AM: (CHECK ONE)

☐ A DOMESTIC VIOLENCE SERVICE PROVIDER
☐ A MEDICAL, PSYCHOLOGICAL OR SOCIAL SERVICE PROVIDER
☐ A LAW ENFORCEMENT PROFESSIONAL
☐ A COUNTY CHILDREN AND YOUTH REPRESENTATIVE
☐ A LEGAL REPRESENTATIVE
☐ AN ACQUAINTANCE/FRIEND/RELATIVE/NEIGHBOR OF THE CLAIMANT
☐ OTHER (SPECIFY): ______________________

I have knowledge of the claimant's experience with and/or steps to escape domestic violence and submit this statement to verify that compliance with the TANF/CCIS program requirement(s) checked above may place the claimant and/or household or family members at risk of further domestic violence; make it more difficult for the claimant and/or household or family members to escape domestic violence; or unfairly penalize the claimant and/or household or family members who is or has been victimized by domestic violence.

______________________ DATE
______________________ THIRD PARTY SIGNATURE

4. SELF-AFFIRMATION

I affirm that compliance with the TANF/CCIS program requirement(s) checked above would place me and/or my household or family members at risk of further domestic violence; make it more difficult for me or a member of my family or household to escape domestic violence; or unfairly penalize me or a member of my family or household who is or has been victimized by domestic violence. I do not have and am unable to safely obtain evidence to verify the domestic violence.

______________________ DATE
______________________ CLIENT SIGNATURE

5. GOOD CAUSE DECISION (CAO USE ONLY)

☐ EXCUSED ☐ NOT EXCUSED

______________________ WORKER
______________________ DATE

DPW Cash Assistance Handbook sections regarding RESET exemptions for parents of young children

135.2 EXEMPTIONS FROM RESET ENROLLMENT

135.22 NEWBORN EXEMPTION

A single custodial parent, in a one-parent household, caring for a child under the age of 12 months for a maximum of 12 months during the parent's lifetime may be exempt. The months do not need to be consecutive and the child is not required to be on TANF.

55 Pa. Code § 165.21 (c) 4

The 12- month count begins the date the individual informs the caseworker that he or she wants to take the exemption and ends when:

- The parent has used his or her 12-month lifetime limit;
- The child turns 12 months of age; or
- The parent chooses to stop taking the exemption.

An individual with a child under one may choose not to take some or all of this exemption due to the lifetime 12-month time limit.

If the individual has not used the full 12-month exemption, the remaining days of the lifetime limit may be used for subsequent births or adoptions.

Once this 12-month limit has been fully used, even if it was used in another state, an individual may not receive it again. The CAO must review the individual's history including:

- The current case record;
- Previous case records;
- The CIS narrative;
- The CQINDA history screen in CIS;
- The CQPREN screen history in CIS to look for good cause given to the parent in a two-parent household who is caring for a child under 12 months of age;

AND

- Contact the other state for any newborn exemption time already used.

Individuals who chose to take the exemption may volunteer to pursue education, job skills training, or work activities.

135.3 GOOD CAUSE

An individual mandatory to participate in RESET may be unable to participate for some of the required hours even if the individual is not exempt as listed in **section 135.2**.

135.31 GOOD CAUSE CIRCUMSTANCES

19. Six weeks following the birth of a child;

NOTE: Good cause is used for the 6 week post-partum period following the birth of a child. Good cause is not granted for being in the last trimester of pregnancy. If an individual has medical complications related to a pregnancy, a licensed medical provider must complete a PA 635 or 1663 to verify that the individual should be exempted from participation.

NOTE: In a two-parent household when both parents are mandatory, one parent may be given good cause to care for the child for a maximum of 12 months in the parent's lifetime or until the child reaches the age of 12 months.
In a two-parent household where one parent is a non-eligible adult, sanctioned, or medically exempt the other parent can be given good cause if it is verified that the non-participating parent cannot care for the child. The Newborn Exemption is not available to two-parent families.

OPS090904 Implementing Caregiver Exemption (Linked September 30, 2010)

23. At application, one parent in a two-parent household is already meeting the hourly participation requirements while the other parent is caring for the child(ren).

Medical Certification to Prevent Utilities Shut Off

PECO ENERGY

REQUEST FOR MEDICAL CERTIFICATION
(Solicite para la certificación médica)

PECO Energy Company
2301 Market Street, N4-1
PO Box 8699
Philadelphia, PA 19101

TO BE COMPLETED BY THE COMPANY:

Account Number:
Name and Service Address of Customer:

Mailing Date:
Address: PECO Energy Company
PO Box 41466
Philadelphia, PA 19101
Phone No. 1-800-494-1000
Fax No. 1-810-713-8196

We received information that someone at your service address is seriously ill and that shutting off your PECO Energy service may cause their condition to get worse. We will not shut your service off if you do all of the following:

- Have the doctor treating the person who is seriously ill complete and sign this form; and
- Return the completed and signed form to us within 7 days of the above mailing date; and
- Make arrangements with us to address any items checked below:

☐ Pay you past-due bill. You are still responsible to keep your bill paid and up to date.

☐ Let us read your meter – Call for an appointment.

☐ Other:______________________________

To talk to us, please call us at 1-800-494-4000 or visit our office at 2301 Market St., Philadelphia, PA 19101.

If we do not receive the completed, signed form within 7 days of the above mailing date, your PECO Energy service may be shut off after we send you the required notices. PECO Energy retains the right to verify any information supplied. Forms that are incomplete or contain information that cannot be verified may be rejected.

Atencion

Este es un mensaje may importante. Si used no lo entiende, vafor de llamar al numero telephone que en este ocumento.

TO BE COMPLETED BY DOCTOR:

Name of person who is seriously ill:______________________________
Relationship to the customer:______________________________
Address (if other than above):______________________________
Nature of illness:______________________________
Specify the reason your patient needs electric/gas service to maintain their health:______________________________

How long do you expect the illness to last?

I certify that in my professional opinion, the person above is seriously ill or has a medical condition that will become worse without electric/gas service.

Doctor's Signature (License Number)
(You may be subpoenaed to testify to the accuracy of this information.)

Date Signed

Office Address

Office Phone Number

Revised—12/00

NCO-002

Philadelphia Gas Works
MEDICAL EMERGENCY CERTIFICATION FORM

TO BE COMPLETED BY CUSTOMER OR APPLICANT FOR MEDICAL PROTECTION:

PGW Account Number: ______________________

PGW Customer's Name: ______________________

PGW Customer's Address: ______________________

Philadelphia, PA 191______________________

Customer's Phone Numbers:
Day (____)______________________
Evening (____)______________________
Please contact me during the ___day ___evening

Customer's Representative (if any):
____
____

RETURN TO: CREDIT/COLLECTION DEPARTMENT
PHILADELPHIA GAS WORKS
800 West Montgomery Avenue
Philadelphia, PA 19122

PGW's Phone: (215) 235-1777
PGW's Fax: (215) 684-6150

If you are a tenant and the delinquent gas bill is in your landlord's name, fill in your name, address, and phone number(s) below:
____
____
____

YOUR GAS SERVICE MAY BE SHUT OFF UNLESS THIS FORM IS COMPLETED AND SIGNED BY A QUALIFIED HEALTH CARE PROVIDER AND RETURNED TO PGW, AT THE ADDRESS OR FAX NUMBER ABOVE, BY ___/___/___. IF SERVICE IS NOW OFF, PGW MAY REFUSE TO TURN IT ON UNTIL A COMPLETED FORM IS RECEIVED.

PGW USE ONLY: Initial_____ Renewal_____ Certificate Service is now ON_____ OFF_____ Mailing_____ Delivery_____ Date:___/___/___

TO BE COMPLETED BY A LICENSED DOCTOR OR LICENSED HEALTH CARE PROFESSIONAL

I certify, that in my professional opinion, the absence of gas service for ___ cooking ___hot water ___heat will aggravate an existing severe medical condition of the following person, who is a resident at the above address.

Name of Patient: ______________________ Age: ______________________

Anticipated Duration of Condition in Days: ______________ Gender: ______________________

____
(Print or Type) Name & Title of Health Care Provider

____
Signature of Licensed Health Care Provider

State or License or Registration: ______________________ State License/Registration/Permit No. ______________________

NOTE: If you are not a physician, you must be licensed or registered by the Commonwealth of Pennsylvania.

Office Address: ______________________
____

Office Phone No .(____)______________________
Office Fax No. (____)______________________

- **PHILADELPHIA GAS WORKS HAS THE RIGHT TO VERIFY THE INFORMATION ON THIS FORM.**
- **TO AVOID SHUT OFF OF GAS SERVICE. THE CUSTOMER MUST MAKE A PAYMENT AGREEMENT ON THE UNPAID UNDISPUTED PAST DUE BALANCE WITHIN 30 DAYS OF ACCEPTANCE OF THIS CERTIFICATE.**
- **THIS CERTIFICATE CAN BE USED TO STOP SHUT OFF OF SERVICE OR TO HAVE SERVICE TURNED ON FOR A 30 DAY PERIOD. IF THE CUSTOMER CANNOT MAKE PAYMENT ARRANGEMENTS WITH PGW WITHIN THESE 30 DAYS, SERVICE CAN BE SHUT OFF UNLESS THIS CERTIFICATE IS RENEWED.**
- **A CERTIFICATE CAN ONLY BE RENEWED ONE TIME. THIS WILL KEEP SERVICE ON FOR ANOTHER 30 DAYS, BUT NO ADDITIONAL CERTIFICATES WILL BE ACCEPTED FOR A 12 MONTH PERIOD.**
- **CUSTOMERS WHO USE A CERTIFICATE TO HAVE SERVICE TURNED ON ONCE, AND WHOSE SERVICE IS TURNED OFF AGAIN FOR NON-PAYMENT, MAY NOT BE ABLE TO GET SERVICE TURNED ON A SECOND TIME WITHIN ONE YEAR BECAUSE OF A MEDICAL EMERGENCY.**

DATE

XX
XXXXX
XXXXXX

RE: Client
Client's Address
Client's Date of Birth

Dear Dr. XX:

As we have discussed earlier, unlike some other utility service providers, the Water Revenue Bureau does not have a 'Medical Certification' form; rather, they simply require a letter from the client's doctor, on letterhead, identifying the patient, doctor (with the doctor's signature), and clinic, wherein the doctor explains specifically why the client medically requires the water service to be turned on. The client's date of birth is XXXX, and he has already told the Water Revenue Bureau that he has HIV/AIDS. The letter should be faxed to the **Water Revenue Bureau, Attn: Medical Emergency at fax number (215) 686-2711.**

If you have any questions, please do not hesitate to call me at (215) 587-9377. I thank you in advance for your prompt assistance in this matter.

Sincerely,

Bureau of Professional and Occupational Affairs Policy Statement Interpreting the Term "Infectious, Communicable or Contagious Disease

PENNSYLVANIA
Department of State

PA STATE AGENCIES

Department of State

Licensing

Directions to DOS

General Information

Business-Related Boards

Health-Related Boards

List Requests

Disciplinary Actions

Professional Health Monitoring Programs (PHMP)

FAQs

Complaints

Calendar

Newsletters Archive

My License

Verify a License

Site Tools

Voting and Elections

Notaries

Certifications, Apostilles, and the Authentication of Documents

Bureau of Professional and Occupational Affairs provides administrative and legal support to 29 professional and occupational licensing boards and commissions. Professional licensing protects the health, safety and welfare of the public from fraudulent and unethical practitioners. Professionals range from Physicians and Cosmetologists to Accountants and Funeral Directors.

Contact us

P.O. Box 2649
Harrisburg, PA 17105
P: 717-787-8503
Send us e-mail

Pennsylvania has two new professional boards: the State Board of Crane Operators and the State Board of Massage Therapy.

Crane operator information is available by selecting Business-Related Boards in the left navigation.

Massage therapy information is available by selecting Health-Related Boards in the left navigation.

Bureau of Professional and Occupational Affairs Policy Statement Interpreting the Term "Infectious, Communicable or Contagious Disease"

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BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
POLICY STATEMENT INTERPRETING THE TERM

"INFECTIOUS, COMMUNICABLE OR CONTAGIOUS DISEASE"

The Bureau of Professional and Occupational Affairs (Bureau) and its 29 licensing Boards are committed to strict compliance with Title II of the Americans with Disabilities Act (ADA), which prohibits discrimination against qualified individuals on the basis of disability. At this time, a number of professional and occupational licensure laws administered by the Bureau and its Boards either prohibit the licensure of individuals with infectious, communicable or contagious diseases, or permits licensees to be disciplined for practicing one's profession or occupation when the licensee knows he or she has an infectious, communicable or contagious disease. Some communicable diseases result in disabilities protected by the ADA. Therefore, the Bureau, in accordance with the ADA and guidance from the United States Department of Justice, has determined that, for the purposes of administering the professional and occupational licensing laws over which it or any of its 29 licensing Boards have jurisdiction, the terms "infectious disease," "communicable disease" or "contagious disease" do not include diseases, such as HIV, that are not transmitted through casual contact or through the usual practice of the profession or occupation for which a license is required.

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