Utilicare Application for Additional Lifeline Allowance

Medical Equipment Requiring Electricity
&
Supplemental Space Conditioning

The City of Riverside Public Utilities' Electric Rate provides for a lifeline quantity of electricity at an adjusted rate for eligible residential customers where a FULL-TIME RESIDENT of the household regularly requires use of:

- An essential electric medical device (qualifying devices listed below.) Non-approved device requests are subject to review and approval;
- Permanently installed electric space heating for paraplegic, quadriplegic, hemiplegic or multiple sclerosis; and
- Permanently installed electric air conditioning for multiple sclerosis or scleroderma patients.

The application must be filled out completely by the customer and the patient's doctor. All medical information contained in the application is considered "privileged" and confidential and should be treated as such.

BEFORE THE UTILITY ACCOUNT IS ENROLLED IN THIS PROGRAM, ALL PAST DUE BILLS MUST BE PAID.

A new application may be required when there is an address change for the patient. Applications are subject to approval and periodic review by the City of Riverside Public Utilities (RPU). All applications for patients with a doctor-certified, non-permanent medical condition are subject to annual self-certification renewal. A new completed and doctor-signed Utilicare application and doctor's certification must be submitted every two years. When medical equipment is no longer necessary, customers must immediately notify RPU and the Utilicare adjusted rate status will revert back to the standard rate. Any patient who has been doctor-certified with a permanent medical condition will be required to complete and sign a self-certification form every two years stating the resident's eligibility for the Utilicare allowance.

Although RPU makes every effort to supply uninterrupted service, continuous service cannot be guaranteed due to circumstances beyond RPU control; therefore, patients requiring the use of life-support equipment should be advised to provide and maintain their own power backup systems.

Continued service is not guaranteed to any customer class or any customer's unique circumstance, medical or otherwise. Lifeline allowances extended to a customer do not in any way excuse or relieve the customer's responsibility to keep their utility account paid in full. Nonpayment of a Utilicare recipient's RPU account is grounds for forfeiting, limitation, and/or termination of participation in the Utilicare program.

LIST OF QUALIFYING DEVICES		
Aerosol Tent	Hemodialysis Machine	Pressure Pad
Apnea Monitor	Heparin Pump	Pressure Pump
Blood Pump	Hospital Bed	Respirator
Electrostatic Nebulizer	Infusion Pump/Hyperalimentation	IPPB Machine
Electric Nerve Stimulator	Reverse Osmosis System	Suction Device
Feeding Pump	Motorized Wheelchair	Ultrasonic Nebulizer
Heating Device for Respirator	Portable Volume Ventilator	Extremity Pump

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RIVERSIDE PUBLIC UTILITIES UTILICARE APPLICATION

UTILITY ACCOUNT #:	
NAME ON UTILITY ACCOUNT:	**APPLICATION DATE:**
SERVICE ADDRESS:	**ZIP CODE:**
PHONE: ( )	**EMERGENCY PHONE #: ( )**
DO YOU LIVE IN A: ( ) HOUSE ( ) DUPLEX, APARTMENT, OR MOBILE HOME ( ) MASTER METERED APARTMENT/MOBILE HOME (SUB-METERED)	
PATIENT NAME:	**PATIENT IS FULL-TIME RESIDENT AT ADDRESS? ( ) YES ( ) NO**
RELATIONSHIP TO CUSTOMER: ( ) CHILD ( ) SPOUSE ( ) PARENT ( ) OTHER: (Specify)	

FOR MASTER METERED ACCOUNTS ONLY (APARTMENT/MOBILE HOME)

NAME OF APARTMENT COMPLEX OR MOBILE HOME PARK:		
TENANT'S NAME:	**PHONE: ( )**	
ADDRESS:	**SPACE/APT#**	**ZIP CODE:**
SIGNATURE OF OWNER/MANAGER:	**DATE:**	

ANNUAL AGREEMENT

I, THE UNDERSIGNED, HEREBY CLAIM ELIGIBILITY AND PROVIDE AN APPLICATION FOR THE UTILICARE PROGRAM, MEDICAL LIFELINE DEVICES AND OR SUPPLEMENTAL SPACE CONDITIONING EQUIPMENT FOR HOME USAGE. THE DEVICE(S) DESCRIBED IS USED IN MY HOME AND IS AN ESSENTIAL LIFE SUPPORT UNIT(S) POWERED BY RPU. I AGREE TO NOTIFY RPU IMMEDIATELY IF USE OF THE DEVICE(S) IS TERMINATED OR IF ANY MEDICAL APPARATUS IS CHANGED. A NEW APPLICATION AND/OR DOCTOR'S CERTIFICATION FOR THIS RATE WILL BE SUBJECT TO THE APPROVAL OF RPU AND TO ANNUAL RENEWAL AND APPROVAL. I UNDERSTAND THAT LIFELINE PARTICIPATION DOES NOT IN ANY WAY EXCUSE OR RELIEVE MY RESPONSIBILITY TO KEEP MY ACCOUNT PAID IN FULL. NON-PAYMENT OF A UTILITY BILL IS GROUNDS TO FORFEIT MY PARTICIPATION IN THE UTILICARE PROGRAM, AS WELL AS HAVE MY SERVICE LIMITED AND/OR TERMINATED. ALL INFORMATION GIVEN ON THIS APPLICATION IS TRUE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT ANY MISINFORMATION COULD LEAD TO DISQUALIFICATION FOR THIS MEDICAL RATE. I ALSO REQUEST THAT MY PHYSICIAN RELEASE ANY INFORMATION TO RPU FOR VERIFICATION.

CUSTOMER SIGNATURE _____ DATE _____

PATIENT SIGNATURE _____ DATE _____

PHYSICIAN'S CERTIFICATION OF MEDICAL CONDITION AND REQUIRED LIFE SUSTAINING EQUIPMENT

*****Must be signed by a Medical Doctor or Osteopath Licensed to Practice in California**

Patient Name:	**Condition is: ( ) Non-Permanent ( ) Permanent**

Physician's Diagnosed Condition:

Patient's Medical Condition is (select one of the following): ( ) MILD ( ) MODERATE ( ) SEVERE ( ) CRITICAL

LIFE-SUPPORT MEDICAL EQUIPMENT FOR THIS PURPOSE IS DEFINED AS "EQUIPMENT THAT UTILIZES MECHANICAL OR ARTIFICIAL MEANS TO SUSTAIN, RESTORE, OR SUPPLANT A VITAL FUNCTION, OR MECHANICAL EQUIPMENT WHICH IS RELIED UPON FOR MOBILITY WITHIN AND OUTSIDE OF BUILDINGS."

***All REQUIRED Medical Equipment and Supporting information must be filled in below by signing Physician.**

Type of Medical Equipment requiring electricity	**Requires Electricity (Y or N)**	**Requires Water Source Attached to Equipment (Y or N)**	**Required Usage Per Day (Hours)**	**Portable? (Y or N)**	**Back Up Power System? (Hours)**	**Service Interruption Tolerance? (Hours)**	**Indicate if A/C is required for: (L-Life Support) (C-Comfort) (B-Both)**

Note: *If more than 4 devices are required, attach an additional sheet.

PHYSICIAN'S NAME (PRINT):	CA STATE LICENSE NO:
ADDRESS:	PHONE:
CITY, STATE, ZIP	EMAIL ADDRESS:
***PHYSICIAN'S SIGNATURE:	DATE:

FOR CITY USE ONLY

EFFECTIVE: RATE: COMPLETED BY: DATE RECEIVED: