



## Application for Residential Critical Care

### Section I

(To Be Completed By the Customer)

Customer Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Account Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Account Number: \_\_\_\_\_

Secondary Contact: \_\_\_\_\_ Secondary Phone: \_\_\_\_\_

Patient's Name (Eligible Resident): \_\_\_\_\_

I have read, understand, and agree the information contained on this form is accurate and correct. I consent to the release of information on this form concerning patient medical condition for use in processing critical care payment option. I understand this information may be used to determine eligibility of services and any protection related to utility service. I agree to update the form annually, or if condition changes from critical.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Section II

(To Be Completed By the Physician)

Physician Name: \_\_\_\_\_

Texas Medical Board License Number: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Medical Condition: \_\_\_\_\_

Type of Life Sustaining Equipment Used: \_\_\_\_\_

Condition is life threatening without electrical service: Yes No

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please submit form to the Utility Billing Manager for approval. Completed form can be dropped off at office, mailed, or faxed. Any changes in status of customer must be immediately reported to the Utility Billing Department.

Critical application must be updated and approved according to PUC rules. Qualification pursuant to this form does not guarantee service will not be disconnected. Payment arrangements and agreements must be followed.