



- INSTRUCTIONS: 1. Please print all information in capital letters using black or dark blue ink only. 2. Please have your Doctor complete the reverse side. 3. Mail completed application to: Los Angeles Department of Water and Power P. O. Box 515407, Room L63 Los Angeles, CA 90051-6707

LADWP Account Name: Last Name, First Name, Account Number, Initial

Service Address: Street Number Only, Street Name, Apartment Number

Residence Phone Number, Cellular Phone Number, Alternate Phone Number, Email Address, City, State, Zip Code

Patient's Name: Last Name, First Name, Initial

IMPORTANT INFORMATION

- 1. Prior to approval, this application is subject to review by a Los Angeles Department of Water and Power (LADWP) medical doctor and will be reviewed periodically thereafter. 2. As part of this application, the applicant agrees to maintain telephone service to the premises. Failure to do so will result in cancellation of this discount. 3. An LADWP representative may visit the premises to verify the device specification, and must be allowed access. Failure to do so will result in cancellation of this discount. 4. A new application must be filed with the LADWP every two (2) years or when there is a medical status change, change of address, or change in the use of the life-support equipment. Failure to do so will result in cancellation of this discount. 5. Approval of this application by LADWP entitles the customer to the Life-Support Discount, but does not guarantee an uninterrupted power supply to the premises. 6. In the event of an outage, priority in restoration will be given to circuits serving Life-Support customers. However, LADWP does not guarantee that restoration will be accomplished within the Life-Support patient's tolerance time. 7. Life-Support customers are strongly recommended to obtain an independent power back-up system. 8. The Life-Support Equipment Discount does not absolve you of your obligation to pay your water and/or electric bills, nor does it exclude you from possible collection activity or termination of service due to non-payment. 9. You may qualify for additional discounts. For information regarding our Senior Citizen or Disabled Citizen Lifeline Rate, and Paraplegic, Quadriplegic, or Multiple Sclerosis Discount, please call us at (800) 342-5397, or visit www.ladwp.com/lifeline.

AGREEMENT

I, the undersigned, a customer of the City of Los Angeles Department of Water and Power (LADWP), hereby claim eligibility and make application for the electric rate discount for life-support devices within home usage. The device used in my home is essential life-support equipment powered by electricity supplied by LADWP.

I hereby grant LADWP right of access to my residence at any reasonable time for verification of information given in this application. I understand that refusal of access for this purpose will be considered just cause for rejection of this application in its entirety. I agree to notify LADWP at the immediate termination of use of the life-support equipment, change in medical status (including tolerance time), or change of address.

All information contained in this application is true to the best of my knowledge. I understand that any misinformation may lead to the rejection of this application in its entirety.

Signature of LADWP Account Holder, Date

STATEMENT OF CERTIFICATION

To be completed by a Medical Doctor or Osteopath licensed to practice medicine in the State of California

PLEASE PRINT ALL INFORMATION LEGIBLY and ANSWER ALL QUESTIONS COMPLETELY

1. What is the patient's diagnosis? (If more than one, list all) _____
2. Describe equipment required by the patient: _____
3. Does the equipment require an uninterrupted flow of water to operate properly? YES NO
4. To be eligible for a rate discount, essential life-support equipment must be involved. Such equipment is defined as any medically-oriented object or device used to monitor or treat an individual without which life could not be maintained beyond a reasonable time. In your opinion, does the above-described equipment meet these criteria? YES NO
5. How long has the patient been using the life-support equipment at his/her present address? _____
6. How long will the patient be required to use such equipment? (Please provide specific date, if there is one.)
 _____ Days _____ Weeks _____ Months _____ Years Other _____
7. What is the distance from the patient's home to the nearest hospital? _____
8. Is there any electrically powered special equipment needed to support the major life-support equipment? YES NO
9. Can the electrically-powered equipment be operated on an auxiliary source such as a hand pump (crank) or battery?
 (Please explain.) _____
10. In case of emergency, what is the longest tolerance time your patient can survive without the use of the equipment without producing death or serious physiological damage? (This answer requires a tolerance time be provided in "hours" and/or "minutes.") _____ Hours _____ Minutes
11. What emergency instructions have been given to the patient or equipment operator should an electrical power outage occur?
 (Please explain.) _____

I hereby certify that (patient's name - First, MI, Last) _____ regularly requires the use of the equipment powered by electricity supplied by the City of Los Angeles Department of Water and Power.
 This use is temporary permanent

Doctor's Name:	Last Name <table border="1" style="width: 100%; height: 25px; border-collapse: collapse;"></table>	Initial <table border="1" style="width: 30px; height: 25px; border-collapse: collapse;"></table>										
	First Name <table border="1" style="width: 100%; height: 25px; border-collapse: collapse;"></table>	License Number: <table border="1" style="width: 100%; height: 25px; border-collapse: collapse;"></table>										
Address:	Street Number Only <table border="1" style="width: 100%; height: 25px; border-collapse: collapse;"></table>	Street Name <table border="1" style="width: 100%; height: 25px; border-collapse: collapse;"></table>										
	Apartment Number <table border="1" style="width: 100%; height: 25px; border-collapse: collapse;"></table>	<table border="1" style="width: 100%; height: 25px; border-collapse: collapse;"></table>										
	City <table border="1" style="width: 100%; height: 25px; border-collapse: collapse;"></table>	State <table border="1" style="width: 30px; height: 25px; border-collapse: collapse;"></table>										
		Zip Code <table border="1" style="width: 100%; height: 25px; border-collapse: collapse;"></table>										
Telephone Number:	<table border="1" style="width: 100%; height: 25px; border-collapse: collapse;"></table>	Fax Number: <table border="1" style="width: 100%; height: 25px; border-collapse: collapse;"></table>										
Doctor's Signature	<table border="1" style="width: 100%; height: 25px; border-collapse: collapse;"></table>	Date <table border="1" style="width: 100%; height: 25px; border-collapse: collapse; text-align: center;"> <tr><td>M</td><td>M</td><td>-</td><td>D</td><td>D</td><td>-</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr> </table>	M	M	-	D	D	-	Y	Y	Y	Y
M	M	-	D	D	-	Y	Y	Y	Y			

LADWP USE ONLY

Account Number <table border="1" style="width: 100%; height: 25px; border-collapse: collapse;"></table>	REC'D _____ EFF _____
Meter Read _____ Date Tagged _____	Approval <input type="checkbox"/> YES <input type="checkbox"/> NO
Department Representative _____ Comments _____ _____ _____	