Oraahda Macaamilka City Light

Qofka lagu magacaabay Shahaadadaan kaasoo isticmaala qalabka ku shaqeeyo korontada ee lagu taageero nafta waa qof si joogto ah u daggan cinwaanka adeegga hoos lagu muujiyay.

Aniga waxaan fahamsanahay in Shahaadadaan aysan macaamilka ka dhaafi doonin bixinta kharashka adeegga korontada. Aniga waxaan fahamsanahay in marka Shahaadadaan xaqiiso jiritaanka isticmaalka qalabka lagu taageero nafta, go'aanka ku saabsan sii waddida adeegga korontada, xatta haddii aan la bixinin kharashka, saleeysan yahay qofka, mana ka badan doonto 30 maalin. Waxaan kaloo si buuxdo u fahamsanahay in ay dhici karto in la gooyo adeegga korontada haddii lagu fashalo bixinta kharashka sida lagu heshiiyay.

Aniga waxaan fahamsanahay in Shahaadadaan tahay sharci muddada la xaqiijiyay jiritaanka halista nafta ama caafimaadka, mana shaqeeyn doonto in ka badan hal sanno haddii aan la cusboneysiinin.

Magaca Macaamilka: _____

Cinwaanka Adeegga: _____

Saxiixa Macaamilka: _____ Taariikhda: _____

City of Seattle

Seattle City Light

CERTIFICATE OF MEDICAL NECESSITY

Medical Provider's Statement (Check One):

☐ I certify that the person listed below is my patient and uses **recognized life support equipment** requiring an electrical connection and that the termination of electrical service to their residence would create a **life-threatening situation**.

OR

☐ I certify that the person listed below is my patient and has a **health-threatening situation** involving a **temporary** illness or condition in which loss of electrical service could result in prolonging or worsening the illness or condition.

Please complete the following:

1. Patient's Name:_____
2. Patient's Address: _____
3. Patient uses the following life support equipment requiring an electrical connection:

   (Check all that apply)

   ☐ Ventilator (Continuous Mechanical)
   ☐ Oxygen Concentrator (Does not include liquid or cylinder oxygen use)
   ☐ Dialysis (In-home Peritoneal Dialysis only)
   ☐ CPAP or BIPAP device
   ☐ Nebulizer
   ☐ Suctioning device
   ☐ Dispenser (Feeding Pump or Medication Dispenser)
   ☐ Bed Mattress (Electric hospital bed or alternating pressure mattress)
   ☐ Chair (Electric lift chair or electric wheelchair, rechargeable)
   ☐ Other Life Support Equipment (Please specify type): _____
   ☐ Heating/Cooling (Patient is vulnerable to extreme temperatures due to serious long-term medical condition and patient's health will be significantly endangered by the termination of electrical service for heating/cooling).

4. Patient's use of life support equipment is expected to be: **(Check one)**

   ☐ Short-term (Less than 60 days) ☐ Long-term (More than 60 days)

5. For temporary health-threatening situation NOT involving life support equipment, explain how the health of the patient will be significantly endangered by the loss of electrical service:

   _____
   _____
   _____

Signature of Licensed Healthcare Provider: _____

Healthcare Provider's I.D. Number: _____Date: _____

Name (Please Print): _____Phone: _____

Address: _____

Seattle City Light Customer's Statement

The patient named in this certificate who uses electric-powered life support equipment is a permanent resident at the service address shown below.

I understand that this certificate does not relieve me of the obligation to pay for electrical service. If my account becomes past due and the use of life support equipment is documented by this certificate, electrical service may be extended. Without payment or a payment arrangement, electrical service may be disconnected.

I understand that this certificate is valid only for the length of time the medical situation is certified to exist and that it is not valid for more than one year without renewal.

Seattle City Light Account Number _____

Customer Name: _____

Service Address: _____

Customer Signature: _____ Date: _____

Relation to Patient Using Life Support Equipment **(Check one)**:

☐ Self ☐ Spouse ☐ Parent or Guardian ☐ Agent with Power of Attorney

☐ Other please specify): _____

Statement of Patient or Their Representative Using Life Support Equipment

The information I have provided to the licensed healthcare provider is true, and I authorize the release of the information on this certificate to Seattle City Light.

Name (print): _____

Signature: _____ Date: _____

Please list all phone numbers and your e-mail address and check the box next to your preferred method(s) of contact:

☐ Primary Contact Number: _____

☐ Secondary Contact Number: _____

☐ Emergency Contact Number: _____

☐ Other: _____

☐ E-mail Address: _____

MAIL Completed Certificate to:

Seattle City Light Credit Office, P.O. Box 34023, Seattle, WA 98124-4023

OR FAX to: Seattle City Light Credit Office at (206) 233-3748