MORENO VALLEY UTILITY

MEDICAL BASELINE ALLOWANCE APPLICATION

(Used for Medical Baseline Enrollment and Re-Certification)

Part 1: TO BE COMPLETED BY CUSTOMER (please print)

MVU Customer Account No: _____

Customer Name (as it appears on your bill): _____

Medical Baseline Resident's Name (if different): _____

Service Address: _____

Customer Mailing Address (if different): _____

Home Phone :(_____) _____ Work Phone :(_____) _____

Cell Phone :(_____) _____

I understand that:

1. If the doctor certifies the resident's medical condition is permanent, MVU will require completion of a form self-certifying continued resident's eligibility for Medical Baseline every two years.
2. If the Doctor Certifies the resident's medical condition is not permanent, MVU will require completion of a form self-certifying continuing resident's eligibility for Medical Baseline each year and completion of a new application with a doctor's certification every two years.
3. If the resident has a vision disability, I may contact MVU to request special notification when either recertification (to complete a new application with a doctor's certification) or self-certification forms are mailed.
4. MVU cannot guarantee uninterrupted electric service and is not responsible for making alternate arrangements in the event of an electric outage.

I certify that the above information is correct. I also certify that the Medical Baseline resident lives full-time at this address, and requires or continues to require the Medical Baseline Allowance.

I agree to allow MVU to verify this information.

I also agree to promptly notify MVU if the qualified resident moves or Medical Baseline Allowance is no longer needed by the resident.

Customer Signature: _____ Date: _____

The Standard Medical Baseline Allowance is 16.5 kilowatt-hours of electricity per day, which is in addition to to your daily Standard Baseline Allocation.

AFTER COMPLETING THE APPLICATION PLEASE MAIL, FAX, EMAIL OR BRING TO OUR LOCAL OFFICE:

MAILING ADDRESS:
MVU Payment Processing
380 N. San Jacinto Street
Hemet, CA 92543
Fax: 1.877.349.3870

LOCAL OFFICE
14331 Frederick Street. Suite 2
Moreno Valley, CA 92553
E-mail: mvutility@moval.org

MVU
MORENO VALLEY
UTILITY

If you have questions, please call our Customer Service Center at 1.844.341.6469 or visit www.moval.org/mvu

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PART 2: TO BE COMPLETED BY A LICENSED MEDICAL DOCTOR (M.D.) OR DOCTOR OF OSTEOPATHY (D.O.)

I certify that the medical condition and needs of my patient (please print):

Last name _____First name _____

1. **Requires use of a life-support device*: Yes___ No ___ (check one)**

   The following life-support device(s) is/are used in the above named patient's home:

   Device: _____

   Device: _____

   Device: _____

   A qualifying life-support device is any medical device used to sustain life or is relied upon for mobility. This device must run on electricity supplied by MVU. It includes, but is not limited to, respirators (oxygen concentrators), iron lungs, hemodialysis (kidney dialysis) machines, suction machines, electric nerve stimulators, pressure pads and pumps, aerosoltents, electrostatic and ultrasonic nebulizers, compressors, IPPB machines, and motorized wheelchairs.* ***Devices used for therapy rather than life-support do not qualify.*

2. **Requires Heating and Cooling:**

   Standard Medical Baseline Allowances are available for heating and/or cooling if patient is Paraplegic, Quadriplegic, Hemiplegic, has Multiple Sclerosis or Scleroderma. Standard Medical Baseline Allowances are also available if patient has a compromised immune system, life threatening illness, or any other condition for which **additional heating or cooling is medically necessary to sustain the person's life or prevent deterioration for the person's medical condition.**

   Requires Standard Medical Baseline Allowance for heating: Yes___ No___ (check one)
   Requires Standard Medical Baseline Allowance for cooling: Yes___ No___ (check one)

3. **I certify that life support device(s) and/or additional heating or cooling are required for:**

   [ ] No. of Years or [ ] Permanently

   How long can the patient survive without using life support equipment?

   [ ] 2 hours or less [ ] more than 2 hours (check one)

   Doctors's Name: _____ Phone No.:(___) _____

   Office Address: _____

   MD/DO California State License or Military License Number:_____

   Signature of Doctor: _____ Date: _____

FOR MVU USE ONLY Date Received: _____ Medical Baseline Allocation: _____ Electric Unit(s)
Recertification: ( ) Self-certify every 2 years ( ) Self Certify annually: Doctor's certification every 2 years

MVU MORENO VALLEY UTILITY