New_____

Renewal _____

NAVAJO TRIBAL UTILITY AUTHORITY

AN ENTERPRISE OF THE NAVAJO NATION

APPLICATION FOR LIFE-SUPPORT DISCOUNT

A **ten percent** (10%) utility discount rate shall be granted to **qualified** residential customers only. The Navajo Tribal Utility Authority shall determine the qualifications of customers based on the licensed physician's certification

CUSTOMER'S NAME	SOCIAL SECURITY NO.:
ADDRESS	TELEPHONE NO.:
STATE ZIP CODE	CONTRACT ACCOUNT NO.& MRU

PATIENT'S NAME:	BIRTHDATE:	AGE:	RELATIONSHIP TO CUSTOMER:

QUALIFICATIONS CRITERI

A certified, written statement must be provided by the customer's/patient's attending licensed physician that the customer/patient has a serious health condition that would be life threatening, if the utility service was to be discontinued. The statement should be written with reasonable accuracy, which details the condition and probable duration of illness and reasons why termination of utility services will endanger that person's life.

I understand that:

1. The discount provided by this rule is temporary and that my account will be reviewed every six months, in June and December of each year, to determine continued eligibility for the Discount Rate.
2. I hereby grant right of access to my residence during regular business hours to NTUA for verification of information given on this application.
3. The refusal of access for this purpose will be considered just cause for denial of the discount rate.
4. The discount is for only the full time residence of the patient and applies to only one residence.
5. I agree to notify NTUA of the immediate termination of use of the life support device.
6. **My utilities will be disconnected, should my account become delinquent for non-payment.**

I certify that:

1. The person named as a patient named above is a full-time resident of this household.
2. All information given on this application is true to the best of my knowledge. I understand that any misinformation could lead to disqualification or forfeiture of the discount rate.

SIGNATURE OF CUSTOMER	DATE

THIRD PARTY NOTIFICATION: NTUA will send the third party, a copy of any disconnect notice that may be mailed to you. Third party is not required to pay the bill, but they can remind you that your services may be turned off, or they can help you take other steps to avoid having services interrupted.

NAME	TELEPHONE NUMBER
MAILING ADDRESS	E-MAIL ADDRESS

The NTUA reserves the right to terminate the discount or to make such revisions or modifications at any time. NTUA cannot and does not guarantee an un-interruptible supply of electric energy. In situations where the medical condition requires an un-interruptible supply of electric energy, the customer is advised to install some type of backup electric energy supply system.

I do hereby authorize disclosure of my medical condition, for the sole purpose of determining my eligibility for NTUA's life support discount program.	
Patient's/Guardian Signature	Date

PHYSICIAN'S STATEMENT

1. Patient's Name

2. What is the patient's diagnosis?

3. Type of equipment required by the patient (be specific):

4. Can the electrical powered equipment be operated by an auxiliary source such as a hand pump (crank) or battery? ❒ Yes* *If Yes, how long a period? _____ ❒ No

5. To be eligible for the rate discount, essential life support equipment is defined as any medical device requiring NTUA supplied electricity for its operation that is regularly required to sustain the life of a person or relied upon for mobility. To qualify under this rule, the device must be used in the home. The term "life-support device" includes, but is not limited to, respirators, hemodialysis machines, suction machines, electric nerve stimulators, electrostatic and ultrasonic nebulizers, compressors, and IPPB/C-PAP machines.
In your opinion, does the above-described equipment meet this criteria?
❒ Yes ❒ No

6. Is such a life support device used in the home and is it essential to sustain the patient's life?
❒ Yes ❒ No

7. How long can, the patient cope, without electricity before a life-threatening medical condition arises?
_____ Hours _____ Minutes

8. How long will the patient be required to use such equipment?
❒ 0-1 year ❒ 1-2 years ❒ life-time ❒ other
_____

I hereby certify that this patient regularly requires the use of the above equipment in their home, which is powered by electricity.

DOCTOR'S NAME (PRINT)	MEDICAL LICENSE NO.	
ADDRESS	CITY	ZIP CODE
TELEPHONE NO. ( )	SIGNATURE OF DOCTOR	DATE

NTUA use only		
APPROVAL ACTION ❒ YES ❒ NO *	❒ DIAGNOSIS/EQUIPMENT DOES NOT QUALIFY* ❒ OTHER:	
REVIEW DATE:	EFFECTIVE DATE	COMPLETED BY: