RCMU
Rancho Cucamonga Municipal Utility

Medical Support Assistance Application

The Rancho Cucamonga Municipal Utility (RCMU) provides a monthly discount for eligible residential customers where a FULL TIME resident of the household regularly requires the use of essential medical support equipment.

The application must be filled out completely by the customer and the patient's doctor. All medical information contained in this application is considered "privileged" and confidential and should be treated as such. Applications are subject to approval and periodic review by RCMU.

The customer understands that:

- If a doctor certifies the resident's medical condition is permanent, the resident must complete an application self-certifying his/her continued eligibility for the allowance every **two years**.
- If a doctor certifies the resident's medical condition is not permanent, the resident must complete an application self-certifying his/her continued eligibility for the allowance **each year** and submit a doctor's certification every **two years**.
- RCMU makes every effort to supply uninterrupted service, however, due to circumstances beyond RCMU control, continuous service cannot be guaranteed to any customer or any customer's unique situation, medical or otherwise. Therefore, patients requiring the use of life-support equipment should be advised to provide and maintain their own power backup systems.
- The Medical Support Assistance provided to the customer does not in any way excuse or relieve the customer's responsibility to keep their utility account paid in full. Nonpayment of a Medical Support account is grounds for forfeiting, limiting and/or terminating the program, as well as disconnection of service until past due amounts have been paid.

A qualifying life support device may be any one of the following or such other equipment as RCMU may deem eligible.

Aerosol Tent	Apnea Monitor	Compressor / Concentrator
Blood Pump	Electric Nerve Stimulator	Hemodialysis Machines
Electrostatic / Ultrasonic Nebulizer	IPPB Machine	Iron Lungs
Kidney Dialysis Machine	Infusion Pump/Hyperalimentation	Pressure Pad
Pressure Pump	Respirator	Suction Machine / Device

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CUSTOMER INFORMATION		
ACCOUNT NO.:	CUSTOMER NO.:	APPLICATION DATE:
NAME ON ACCOUNT:		
SERVICE ADDRESS:		

PATIENT INFORMATION	
PATIENT NAME:	PATIENT IS FULL-TIME RESIDENT AT ADDRESS [ ] YES [ ] NO
RELATIONSHIP TO CUSTOMER [ ] SELF [ ] CHILD [ ] SPOUSE [ ] PARENT [ ] OTHER _____	
PHONE NO.:	EMERGENCY PHONE NO.:

ANNUAL AGREEMENT

I certify that the above information is correct and the resident lives full-time at this address and requires or continues to require the Medical Support Assistance. I agree to allow RCMU to verify this information at any time and request that my physician release any information to RCMU for certification.

I will notify RCMU immediately if use of the device(s) is terminated or if any medical apparatus has changed.

I understand that participation in this program does not in any way excuse or relieve my responsibility to keep my account paid in full and that non-payment is grounds to forfeit my participation in the program, as well as have my service disconnected.

I understand that RCMU makes every effort to supply uninterrupted service, however, due to circumstances beyond RCMU control, continuous service cannot be guaranteed to any RCMU customer or any customer's unique circumstance, medical or otherwise.

By signing below, I declare under penalty of perjury that the information contained on this application is true and correct.

CUSTOMER SIGNATURE _____

PATIENT SIGNATURE _____

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PHYSICIAN'S CERTIFICATION OF MEDICAL CONDITION AND REQUIRED LIFE SUSTAINING EQUIPMENT
****Must be filled out and signed by a Medical Doctor or Osteopath Licensed to Practice in California**

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

PATIENT'S LAST NAME:	FIRST NAME:
PHYSICIAN'S DIAGNOSED CONDITION FOR PATIENT:	
PATIENT'S MEDICAL CONDITION IS: [ ] NON-PERMANENT [ ] PERMANENT	

PATIENT REQUIRES USE OF A LIFE-SUPPORT DEVICE* *(check one)* [ ] YES [ ] NO

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

Device:

Device:

Device:

Device:

(If more than 4 devices are required, please attach additional sheet)

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

I CERTIFY THAT THE LIFE SUPPORT DEVICE(S) WILL BE REQUIRED FOR APPROXIMATELY: *(check one)*

[ ] No. of Years_____ [ ] Permanent

Doctor's Name *(please print)*:	
Office Address:	
MD/DO California State License Number:	
**Signature of Doctor (MD or DO Signature ONLY):	
Date:	Phone Number: