Public Utility Commission of Texas

Residential Critical Care Eligibility Determination Form

Completion by Retailer

Account ID: _____

Customer Name Associated with Account ID: _____

Service Address: _____

Mailing Address (if different than Service Address): _____

Date Form Sent to Customer: _____

Completion by Customer:

Patient Name (please print):

_____

Telephone Number: Home: _____ Work: _____

Secondary Contact Name: _____

Relationship: _____

Phone Number for Secondary Contact: _____

ATTN: Non-payment of electric bill within 26 days of billing will result in termination of service regardless of registration as a priority cuatomer.

Patient's Signature: _____ Date: _____

Completion by Patient's Physician:

Physician Name: _____

Physician Address: _____

Physician Phone Number: _____

Medical Equipment Information

Type of Electric, Life Sustaining Equipment Used: _____

Medical Diagnosis: _____

Does Customer require on-site back-up capabilities or other alternatives for loss of normal electrical service? (Please mark one) ☐ Yes ☐ No

If Yes, please describe: _____

How long can patient sustain without electrical service? (number of hours) _____

Is condition life threatening without electrical service? (please mark one) ☐ Yes ☐ No

_____

Physician's Signature: _____ Date: _____

This qualification requires renewal one year from the date you are qualified. The information on this form may be subject to verification and additional information may be required from you or your physician.

Qualification pursuant to this form does not guarantee an uninterrupted power supply, and if electricity is a necessity, you may need to make other arrangements.