Direct Energy
Regulated Services®

# Application for Chronic Condition or Critical Care
## Residential Customer Status

# IMPORTANT INFORMATION

- This Application must be completed in order to obtain the designation of Critical Care or Chronic Condition Status by Direct Energy Regulated Services.
- **This Application will not be processed and approved if incomplete, unreadable, or improperly submitted**. All information is required, unless otherwise indicated.
- For questions about this Application, call Direct Energy Regulated Services at 1-866-420-3174 during normal business hours.
- **Submission of this application does not automatically result in Chronic Condition or Critical Care Status.** Notification of the status granted will be provided to the customer at the mailing address provided.
- Designation as a Chronic Condition or Critical Care residential customer does not relieve a customer of the obligation to pay for service, and service may be disconnected for failure to pay.
- **Chronic Condition or Critical Care Status does not guarantee an uninterrupted, regular, or continuous supply of service.**

## INSTRUCTIONS

**Customer:** Complete **PAGE 2** of this application, and provide form to patient's physician for completion. **This application will not be approved unless submitted by fax or email to Direct Energy Regulated Services.**

**Physician:** Complete **PAGE 3** of this application.

Please forward only PAGES 2 and 3 to Direct Energy Regulated Services by fax at 1-877-420-3777 or by email to DERS_Inquiries@directenergy.com.

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# PAGE 2 – To Be Completed by the Customer

## PART 1: ALL INFORMATION IS REQUIRED

**Customer Name:**
*(Name on account)*

**Patient Name:**

*(Name of Patient, who is living permanently at the Service Address, and who needs critical care or chronic condition status. The Patient may be the same person as the Customer.)*

**Service Address:** *(Found on your invoice)*

**City:** **Prov:** **Postal Code:**

**Mailing Address:** *(if different than Service Address)*

**City:** **Prov:** **Postal Code:**

**Electric Site ID:** *(Found on your electric bill)*

| **Customer Primary Phone:** | **Customer Alternate Phone:** (*if any*) |
|---|---|
| | |

**Emergency (Secondary) Contact Information** ***(Your application will be rejected unless you include an emergency contact name or insert "I choose not to provide an emergency contact name". Failure to include an emergency contact may result in disconnection of your service without notice if Direct Energy is unable to contact you.)***

**Name of Emergency Contact:**

**Mailing Address:**

**City:** **State:** **ZIP:**

| **Phone:** | **Alternate Phone:** (*if any*) |
|---|---|
| | |

**Customer:**
I have read and understood the information and certify that the information provided on this Application is correct. I understand the information may also be used to determine whether I am eligible for additional notices and other protections relating to my electric service available under Commission/Direct Energy rules, and may be used to provide notices relating to my services to the Emergency Contact.

**Signature:** **Date:**

**Patient/ Patient's Guardian, Parent, or Managing Conservator:**
I have read and understood the information and certify that the information provided in this application about me (or the patient) is correct. I agree to the release of the information on this form concerning my (or the patient's) medical condition for the purposes stated on this application.

**Signature:** **Date:**
***(Signature required, even if same person as Customer)***

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# PAGE 3 – To Be Completed by the Patient's Physician

| FROM PAGE 2: |
|---|
| Patient Name: |
| Customer Name:<br><br>SITE ID(s): |
| |
| **PART 2: ALL INFORMATION IS REQUIRED** |

| Option #1 | YES | NO |
|---|---|---|
| 1) The patient is dependent upon an electric-powered medical device **to sustain life**. | | |

## -AND/OR-

| Option #2 | YES | NO |
|---|---|---|
| 2) The patient has a serious medical condition that requires an electric-powered medical device or electric heating or cooling to prevent impairment of a major life function through a significant deterioration or exacerbation of the person's medical condition. | | |
| a) If yes to # 2 above, has the above medical condition been diagnosed as a life-long condition? | | |

| **Physician Name:**<br>(printed) | |
|---|---|
| **Medical Board License Number:** | |
| **Phone:** | **Fax:** |
| **Physician Signature:** | **Date:** |

Please forward a signed Application to:
Direct Energy Regulated Services by fax at 1-877-420-3777 or
email to DERS_Inquiries@directenergy.com.

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