

# Application for Medical Equipment Discount (MED) Rate

## 1. Customer information

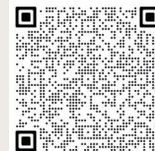
\_\_\_\_\_  
Last name First name

\_\_\_\_\_  
Service address

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
SMUD account number (found on paper bill and/or online)  
(Or name of mobile home park if your electricity is submetered)

Download and print application  
at [smud.org/MED](http://smud.org/MED)



Mail completed application to:

Sacramento Municipal Utility District  
MED Rate, Mail Stop A104  
P.O. Box 15830  
Sacramento, CA 95852-0830

## 2. Mailing address

\_\_\_\_\_  
House number Street name Unit number

\_\_\_\_\_  
City State Zip

## 3. Declaration and signature

- I certify and declare that the information I have provided for this application is true and correct, and contains no material omissions of fact to the best of my knowledge and belief.
- I certify that the patient named in step 4 below is a full time resident of this household and is dependent on a qualifying medical equipment device used in the home or has a medical condition with special electric heating or air conditioning needs.
- The medical equipment device identified on Step 4 is used in my home and is essential medical equipment powered by electricity supplied by SMUD.
- I permit the proper change to my rate schedule and consent to annual eligibility verification.
- I understand that SMUD cannot guarantee uninterrupted electricity service and I am responsible for making alternate arrangements in the event of a disruption in service.

\_\_\_\_\_  
Customer signature Date

***If the MED Rate discount does not meet the electricity needs related to your medical condition or the medical device that you are using, please email [MedicalDiscount@smud.org](mailto:MedicalDiscount@smud.org) or call 1-888-742-SMUD (7683).***



***Please have the back of this application completed and signed by your Qualified Medical Professional. Applications submitted without signatures will be returned.***



# Application for Medical Equipment Discount (continued)

## 4. Medical equipment *To be completed by qualified health professional ONLY*

*This section must be completed by a doctor of medicine, nurse practitioner, family nurse practitioner or physician's assistant licensed to practice medicine.*

Qualified list of medical equipment device operated on a regular basis or extraordinary electricity needs.

Patient: \_\_\_\_\_ requires the use of the following\* (Check Yes or No for each) :

Electric wheelchair	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Ventilator*	<input type="checkbox"/> Yes	<input type="checkbox"/> No
In-home dialysis cyclor	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Extraordinary heating needs	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Oxygen concentrator*	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Extraordinary cooling needs	<input type="checkbox"/> Yes	<input type="checkbox"/> No

\*CPAP/BIPAP machines are not qualifying devices.

\_\_\_\_\_  
Qualified health professional's name

\_\_\_\_\_  
Office street address

\_\_\_\_\_  
Phone number

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

### Declaration and signature

- I certify that the medical device(s) indicated above are required for this patient.

\_\_\_\_\_  
Qualified health professional's signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
License number

\_\_\_\_\_  
State

☐ Please check box if medical device(s) indicated above are required **permanently** for this patient.

***If the MED Rate discount does not meet the electricity needs related to your medical condition or the medical device that you are using, please email [MedicalDiscount@smud.org](mailto:MedicalDiscount@smud.org) or call 1-888-742-SMUD (7683).***

