



GUARDIAN

CUSTOMER INFORMATION

Name		
Address		
Account Number		
Daytime Contact	Name:	Phone:

PROGRAM GUIDELINES

Guardian provides monthly bill discounts for customers with doctor prescribed electrically powered medical equipment and space conditioning needs. Discounts are not authorized for devices used for therapeutic purposes, such as whirlpool pumps, heating pads, vaporizers, humidifiers, pool or tank heaters, saunas, hot tubs, medical devices used outside the home, and non-electric powered medical devices. Equipment not listed below may be approved on a case by case basis. Please allow 30-60 days to process your application.

CONDITIONS FOR PARTICIPATING

1. Must be a GWP electric customer.
2. Medical equipment must be electrically powered and prescribed by a doctor.
3. Participant must reapply each time they move and recertify eligibility annually or when requested.
4. Participant must notify GWP within thirty (30) days if they become ineligible for the program.
5. Must allow GWP access to the home to determine the manufacturer and ampere if requested by GWP.
6. Must acknowledge that GWP does not guarantee continuous power, and declare the number of hours of emergency backup arranged for by the customer.
7. Eligible medical equipment includes:

Aerosol Tents	Heparin Pump	Oxygen Concentrators
Apnea Monitors	Infusion Pump	Pressure Pumps
Blood Pump	Iron Lung	Respirators
CPAP / BiPAP	Kidney Dialysis	Reverse Osmosis
Extremity Pump	Motorized Wheelchairs	Suction Machines
Feeding Pump	Nerve Stimulators	Ventilators
Hemodialysis	Nebulizers	
8. Customers with special medically prescribed electric heat or air conditioning needs may also be eligible for the program on a case by case basis. Eligible conditions include households with paraplegic, quadriplegic, or hemiplegic members and/or households with members suffering from scleroderma and/or multiple sclerosis.

MUST COMPLETE AND SIGN REVERSE

MEDICAL EQUIPMENT INFORMATION

Information regarding the amperes, manufacturer, and model number can be found on the metal faceplate attached to the outside surface of the device.

<u>1. Medical Equipment Name</u>	<u>Manufacturer/Model Number</u>	
<u>Equipment Provider Telephone Number</u>	<u>Amperes</u>	<u>Hours Used Per Day</u>
<u>2. Medical Equipment Name</u>	<u>Manufacturer/Model Number</u>	
<u>Equipment Provider Telephone Number</u>	<u>Amperes</u>	<u>Hours Used Per Day</u>
<u>3. Medical Equipment Name</u>	<u>Manufacturer/Model Number</u>	
<u>Equipment Provider Telephone Number</u>	<u>Amperes</u>	<u>Hours Used Per Day</u>

I certify under penalty of perjury that the information provided herein is true and correct. I understand that providing misinformation can disqualify me for this and other PBC programs. I understand that GWP CANNOT GUARANTEE CONTINUOUS ELECTRIC SERVICE. IT IS MY RESPONSIBILITY TO MAKE BACKUP ARRANGEMENTS IN CASE OF A POWER OUTAGE. I further agree to give GWP access to my home to determine the manufacturer and ampere rating of my equipment if none is supplied, and for program auditing purposes.

IN CASE OF A POWER OUTAGE, I HAVE _____ HOURS OF EMERGENCY ELECTRICAL COVERAGE

_____ **CUSTOMER SIGNATURE**

_____ **DATE**

MEDICAL DOCTOR SECTION ONLY

This section is to be completed by the prescribing medical doctor of the person living in the household with the special medical equipment or space conditioning need

Patient's name: _____

Patient suffers from _____

and requires the following medical equipment:

Type of Equipment Prescribed	Hours per day	Months/Lifetime

Is one or more of the above conditions considered necessary for life support? **YES / NO**

Patient has scleroderma or multiple sclerosis and requires special space heating? **YES / NO**

Patient is a paraplegic, quadriplegic, or hemiplegic and requires special space cooling? **YES / NO**

_____ **Doctor's Name**

_____ **Phone #**

_____ **Medical License #**

_____ **Doctor's Signature**

_____ **Date**