



# GUARDIAN



## 1. CUSTOMER INFORMATION

Name on GWP Account:

Address:

GWP Account Number:

Daytime Contact Name:

Phone:

## 2. PROGRAM GUIDELINES

Guardian provides monthly bill discounts for customers or household members 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/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.

## 3. INCOME STATUS

Your answer to the following question does not affect your eligibility in the discount program.

Are you Low-Income?  YES (Go to section 4)  NO (Go to section 6)

## 4. PUBLIC ASSISTANCE PROGRAMS (For low-income applicants only)

If you, or someone in your household, receives benefits from any of the programs listed below, please check the box and provide a copy of your benefit card or other proof of current period enrollment for programs checked. If you checked one of the boxes below, **Skip section 5 and go to Section 6.**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Medi-Cal/Medicaid       | <input type="checkbox"/> CalWORKs (TANF)                 | <input type="checkbox"/> National School Lunch Program(NSLP) |
| <input type="checkbox"/> CARE Program (SoCalGas) | <input type="checkbox"/> California Lifeline (Telephone) | <input type="checkbox"/> WIC                                 |
| <input type="checkbox"/> SSI                     | <input type="checkbox"/> Medi-Cal for Families           | <input type="checkbox"/> LIHEAP                              |
| <input type="checkbox"/> CalFresh (Food Stamps)  | <input type="checkbox"/> Section 8/HUD                   |  |

## 5. SOURCE OF INCOME (For low-income applicants only)

Please check the appropriate box for all sources of income for all persons in your household and **provide copies of current documents** for all sources checked below.

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> SSA, SSI, SSP, SSDI      | <input type="checkbox"/> Wages or Salaries     | <input type="checkbox"/> Interest, Dividends, Annuities |
| <input type="checkbox"/> Pensions                 | <input type="checkbox"/> Unemployment Benefits | <input type="checkbox"/> Rental or Royalty Income       |
| <input type="checkbox"/> Family Support           | <input type="checkbox"/> Workers Compensation  | <input type="checkbox"/> Profit and Loss Statement      |
| <input type="checkbox"/> Spousal or Child Support | <input type="checkbox"/> Scholarships, Grants  | <input type="checkbox"/> Cash or other income           |

The total number of residents living in my home, including myself: \_\_\_\_\_

## 6. CONDITIONS FOR PARTICIPATING

- Must be a GWP electric customer or a household member with a doctor prescribed special electric-powered medical equipment or with space conditioning needs. Only one discount is allowed per household.
- Participant must reapply each time they move and recertify eligibility annually or when requested.
- Participant must notify GWP within thirty (30) days if they become ineligible for the program.
- Must allow GWP access to the home to determine the manufacturer and ampere if requested by GWP.
- Must acknowledge that GWP does not guarantee continuous power, and declare the number of hours of emergency backup arranged for by the customer.
- Eligible medical equipment includes:

Aerosol Tent	Extremity Pump	Infusion Pump	Nerve Stimulator	Reverse Osmosis
Apnea Monitor	Feeding Pump	Iron Lung	Nebulizer	Respirator
Blood Pump	Hemodialysis	Kidney Dialysis	Oxygen Concentrator	Suction Machine
CPAP/BiPAP	Heparin Pump	Motorized Wheelchair	Pressure Pump	Ventilator
- 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.



### 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.

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

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**

\_\_\_\_\_  
**GWP 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: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient suffers from \_\_\_\_\_ Kaiser MRN Number: \_\_\_\_\_

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**

Does the patient require special space heating or cooling? **YES / NO**

Patient has scleroderma or multiple sclerosis? **YES / NO**

Patient is a paraplegic, quadriplegic, or hemiplegic? **YES / NO**

\_\_\_\_\_  
**Doctor's Name**

\_\_\_\_\_  
**Phone #**

\_\_\_\_\_  
**Medical License #**

\_\_\_\_\_  
**Doctor's Signature**

\_\_\_\_\_  
**Date**

**Please mail application and copies of all supporting documents to:**

Glendale Water & Power  
Conservation and Utility/Business Modernization Division  
141 N. Glendale Ave., Level 2  
Glendale, CA 91206-4496  
(818) 548-3368  
[www.GlendaleWaterAndPower.com](http://www.GlendaleWaterAndPower.com)