MEDICAL EQUIPMENT ENERGY USAGE ASSISTANCE PROGRAM
INFORMATION AND APPLICATION INSTRUCTIONS

Who can apply?

Any customer whose household is served by IID and requires the use of electric devices for medical reasons. The program is intended for residential customers only. The MEEUAP assistance is capped to three customers per residential household.

How to Apply

1. Complete and sign application.
2. Part 1 to be completed by customer.
3. Part 2 to be completed by doctor.
4. Submit completed application to ***energyassistance@iid.com,*** by fax to **760-339-9744** or mail to:

Imperial Irrigation District
Energy Assistance Programs
PO Box 937
Imperial, CA 92251-0937

You can also apply at the following Customer Service Centers:

Brawley	Calexico	El Centro	La Quinta
135 S. Plaza St.	**301 Imperial Ave.**	**1285 Broadway**	**81-600 Avenue 58**

Office hours: Monday - Thursday, 7:30 a.m - Noon & 1 - 5:30 p.m.

Any incomplete or false information on this application may cause IID to postpone, deny or stop the Medical Equipment Energy Usage Assistance Program (MEEUAP) rate to the customer. Applicants will receive the program rate once the application is approved by IID, no retroactive benefits will be afforded to the customer.

You must agree to let IID know if any of the following occur:

- The person with the qualifying illness no longer lives with you *(or your tenant)*
- The equipment or hours of use change *(by the doctor)*
- The equipment is no longer used in your home *(or your tenant's home)*
- You move to another address and want the program applied to your new address

Renewals:

- To avoid interruption of your discount, it is recommended you apply 1-2 months prior to expiration.
- Your discount period is for 18 months from the day approved.

General Disclaimers:

- Your primary residence must be in IID's service area.
- This program is subject to funding availability and may change without prior notice.
- Account must be in good standing to qualify.

You Do Not Qualify for MEEAUP if:

- You have an account assign for collections.
- You have a history of unauthorized and unmetered energy consumption or meter tampering.
- You have a business/commercial account.

For more information on MEEAUP, please contact IID or visit our website at ***www.iid.com.***
1-760-339-9032 (MEEAUP Representative) • **1-800-303-7756** (Customer Service)

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MEDICAL EQUIPMENT ENERGY USAGE ASSISTANCE PROGRAM APPLICATION

IID — A century of service.

PART 1: TO BE COMPLETED BY CUSTOMER. (Entire application must be completed and signed. Please print clearly.)

Name *(as shown on your IID bill)*		Customer Account #
Service Address		
City	State	Zip Code
Telephone Number		Email
Name of Patient		Relationship to Customer

For electricity paid by property owner (master meter accounts):

Name of Tenant	Telephone Number

Do you have a backup generator, battery pack or other equipment for life support or mobility in case of a power outage?

☐ Yes -- How many hours of backup will it provide? _____ ☐ No

Provide the following information for each piece of equipment (found on the manufacturer data plate). Please do not abbreviate the name of the equipment or its manufacturer.

Name of equipment	Full name of manufacturer	Watts	Volts	Amps	Hours/Days of use

Please use an additional sheet if you need more space.

IID reserves the right to visit your home (or your tenant's home) during reasonable hours to verify the information on this application. If you refuse to allow IID to visit your home (or your tenant's home) to verify the information on this application, IID may not grant, or may discontinue, the Medical Equipment Energy Usage Assistance Program allocation.

Although Imperial Irrigation District will make every effort to supply uninterrupted service, continuous service cannot be guaranteed. In the event of a power outage, patients requiring the use of **life-support equipment** are responsible for providing their own backup power system. Program participation does not guarantee service on delinquent or past due accounts.

Customer Signature _____ Date _____

FOR OFFICE USE ONLY

Installation _____ Qualifying Medical Equipment Usage _____ A/C _____

Effective Dates _____ Approved/Denied By: _____

PART 2. TO BE COMPLETED BY LICENSED MEDICAL DOCTOR OR DOCTOR OF OSTEOPATHY

Name of patient _____

The patient medically requires increased heating and/or cooling and has one of the following:

☐ Paraplegia ☐ Hemiplegia ☐ Quadriplegia ☐ Multiple Sclerosis

☐ Scleroderma ☐ Life-Threatening Illness ☐ Compromised Immune System

What life support equipment does your patient need to use regularly?	Is this equipment necessary to sustain, restore, or supplant a vital function, or permit mobility?	Number of hours equipment is used daily?	How long (months/years) do you think patient will need equipment?
☐ Apnea Monitor (C-PAP)	☐ Yes ☐ No		
☐ Compressor/Concentrator	☐ Yes ☐ No		
☐ Electric Nerve Stimulator	☐ Yes ☐ No		
☐ Electrostatic Nebulizer	☐ Yes ☐ No		
☐ Heating Device for Respirator	☐ Yes ☐ No		
☐ Hospital Bed	☐ Yes ☐ No		
☐ Infusion Pump/Hyperalimentation	☐ Yes ☐ No		
☐ Motorized Wheelchair (Battery Charging Unit)	☐ Yes ☐ No		
☐ Portable Volume Ventilator	☐ Yes ☐ No		
☐ Pressure Pad	☐ Yes ☐ No		
☐ Pressure Pump	☐ Yes ☐ No		
☐ Respirator	☐ Yes ☐ No		
☐ Suction Device	☐ Yes ☐ No		
☐ Ultrasonic Nebulizer	☐ Yes ☐ No		
☐ Other_____	☐ Yes ☐ No		
_____	☐ Yes ☐ No		
_____	☐ Yes ☐ No		

During a service interruption, if your patient did not have a backup system, how long could your patient survive without using the **life-support equipment** that you describe?

☐ Hours -- How many?_____ ☐ Days -- How many?_____

Name, address, telephone and license number of physician:

Name	*M.D./D.O./P.A./N.P. (Circle One)*		Business Telephone Number
Business Address	City	State	Zip Code

I hereby certify that the above information reflects my medical judgement regarding this patient's needs for equipment necessary for life support or mobility.

_____ _____

Signature of M.D./D.O. Date Doctor's License Number Exp. Date