



ENERGY ASSISTANCE FOR SPECIAL EQUIPMENT PROGRAM INFORMATION AND APPLICATION INSTRUCTIONS

Who can apply?

Any customer whose single-family household is served by IID and requires the use of electric devices for medical reasons. The program is intended for residential customer accounts only. The EASE program assistance is capped to three patient(s) per residential household.

HOW TO APPLY

1. Complete and sign application (*also available for download at www.iid.com/ease*).
2. Part 1 to be completed by customer.
3. Part 2 to be completed by doctor.
4. Submit completed application to **EASE@iid.com**, by fax to **760-339-9744**:

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

You can also apply at the following Customer Service Centers:

Brawley 135 S. Plaza St.	Calexico 301 Imperial Ave.	El Centro 1285 Broadway	La Quinta 81-600 Avenue 58	Imperial 333 E. Barioni Blvd.
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🕒 Office hours: Monday - Thursday, 8 a.m - 12 p.m. & 1 - 5 p.m. CLOSED ON FRIDAYS

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

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

- The person using the qualifying medical equipment 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

General Disclaimers:

- Your primary single-family 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.
- In order to qualify, tampering fees need to be paid in full, or have at minimum a 12 month good payment history of the tampering fees.

You Do Not Qualify for EASE if account holder:

- Has an account assigned to collections.
- Your residential home is being used as a business for assisted living/hospice centers.
- Your residential home is not single-family.

Renewals:

- To avoid interruption of your discount, it is recommended you apply 1-2 months prior to expiration.
- Your discount period is for 36 months from the day approved.

For more information on EASE, please contact IID or visit our website at www.iid.com/ease.

1-760-339-9032 (EASE Representative) • **1-800-303-7756** (Customer Service)



ENERGY ASSISTANCE FOR SPECIAL EQUIPMENT APPLICATION

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

Customer Name <i>(as shown on your IID bill)</i>	Customer Contract Account #
Telephone Number	Email
Name of Patient	Relationship to Account Holder
Customer Address	

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

Name of Tenant	Telephone Number
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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	Volts	Amps	Hours/Days of use

Volts and AMPS section must be completed.

Please use an additional sheet if you need more space.

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 continuous service are responsible for providing their own backup power system. Program participation does not guarantee service on delinquent or past due accounts.

Customer Signature _____	Date _____
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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
- Other _____

Physician explanation required for heating/cooling (air conditioning): _____

What equipment does your patient use regularly? (No battery operated equipment)	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?
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|---|------------------------------|-----------------------------|-------|-------|
| <input type="checkbox"/> Apnea Monitor (C-PAP) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ | _____ |
| <input type="checkbox"/> Compressor/Concentrator | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ | _____ |
| <input type="checkbox"/> Electrostatic/Ultrasonic Nebulizer | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ | _____ |
| <input type="checkbox"/> Hospital Bed | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ | _____ |
| <input type="checkbox"/> Motorized Wheelchair (Battery Charging Unit) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ | _____ |
| <input type="checkbox"/> Portable Volume Ventilator | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ | _____ |
| <input type="checkbox"/> Respirator | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ | _____ |
| <input type="checkbox"/> Dialysis Cyler | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ | _____ |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ | _____ |

Name, address, telephone and license number of physician:

Name	<i>M.D./D.O./P.A./N.P. (Circle One)</i>	License # & State	Business Telephone Number
Business Address		City	State Zip Code

I hereby certify that the above information reflects my medical judgement regarding this patient's need for medical equipment as outlined above.

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