Application for Medical Equipment Discount (MED Rate)

1. Customer information

Last name | First name

Service address

City | State | Zip

SMUD Account number
(Or name of mobile home park if your electricity is submetered)

Download and print application at 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

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

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 or call 1-888-742-7683.

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 etraordinary electricity needs.

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

Electric Wheelchair	☐ Yes	☐ No	Ventilator*	☐ Yes	☐ No
In-home Dialysis Cycler	☐ Yes	☐ No	Extraordinary heating needs	☐ Yes	☐ No
Oxygen Concentrator*	☐ Yes	☐ No	Extraordinary cooling needs	☐ Yes	☐ 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

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