IMPORTANT INFORMATION

- This Application must be completed to obtain the designation of Critical Care or Chronic Condition Status with Magic Valley Electric Cooperative.
- **This Application will not be processed and approved if incomplete, unreadable, or improperly submitted.** All information is required, unless otherwise indicated.
- For questions about this Application, please call MVEC at 1-866-225-5683.

- **Submission of this application does not automatically result in Chronic Condition or Critical Care Status.** Notification of the status granted will be provided to the member at the mailing address provided.
- Pursuant to the rules of Magic Valley Electric Cooperative, designation as a Chronic Condition or Critical Care residential member does not relieve a member of the obligation to pay for electric service, and service may be disconnected for failure to pay.
- **Chronic Condition or Critical Care Status does not guarantee an uninterrupted regular, or continuous power supply. If electricity is a necessity, you must make other arrangements for on-site back-up capabilities or other alternatives in the event of loss of electric service.**

INSTRUCTIONS:

- **Member:** Complete PAGE 2 of this application and provide to patient's physician for completion. This application will not be approved unless submitted by email or in person by the physician to **criticalcare@magicvalley.coop**

- **Physician:** After completing **PAGE 3** of the following document, please forward only PAGES 2 and 3 to MVEC to the email address listed above.

PAGE 2 – To Be Completed by the Member

PART 1: ALL INFORMATION IS REQUIRED

Member Name:
(Name on electric account)

Patient's Name:

(Name of Patient, who is living permanently at the Service Address, and who needs critical care or chronic condition status. The Patient may be the same person as the Member.)

Service Address *(found on your electric bill)*

City: **State:** **ZIP:**

Mailing Address *(if different from Service Address)*

City: **State:** **ZIP:**

MVEC Account number*(found on your electric bill)*

Member Primary Phone:	**Member Alternate Phone:** (if any)

Emergency (Secondary) Contact Information ***(Your application will be rejected unless you include an emergency contact name or insert "I choose not to provide an emergency contact name". Failure to include an emergency contact may result in disconnection of your electric service without notice if MVEC is unable to contact you and your electric bill is overdue.)***

Name of Emergency Contact:

Mailing Address:

City: **State:** **ZIP:**

Phone:	**Alternate Phone (if any):**

Member:
I have read and understood the information and certify that the information provided on this Application is correct. I understand the information may also be used to determine whether I am eligible for additional notices and other protections relating to my electric service available under Magic Valley Electric Co-op rules and may be used to provide notices relating to my electric service to the Emergency Contact.

Signature: **Date:**

Patient/ Patient's Guardian, Parent, or Managing Conservator:
I have read and understood the information and certify that the information provided in this application about me (or the patient) is correct. I agree to the release of the information on this form concerning my (or the patient's) medical condition for the purposes stated on this application.

Signature: **Date:**
(Signature required, even if same person as Member.)

PAGE 3– To Be Completed by the Patient's Physician

FROM PAGE 2:	
PATIENT'S NAME:	
MEMBER NAME:	MVEC account #

PART 2: ALL INFORMATION IS REQUIRED

Option #1	**YES**	**NO**
1) The patient is dependent upon an electric-powered medical device **to sustain life**.		

-AND/OR-

Option #2	**YES**	**NO**
2) The patient has a serious medical condition that requires an electric-powered medical device or electric heating or cooling to prevent impairment of a major life function through a significant deterioration or exacerbation of the person's medical condition.		
a) If yes to # 2 above, has the above medical condition been diagnosed as a life-long condition?		

Physician Name: (printed)	
Texas Medical Board License Number:	
Phone:	**Fax:**
Physician Signature:	**Date:**

After completing the Application, please email an electronic copy of the completed and signed application to MVEC.

criticalcare@magicvalley.coop