CUSTOMER SERVICE
119 South Walnut Street
Milford, DE 19963

THE CITY of Milford DELAWARE

PHONE 302.422.6616
FAX 302.422.1120
www.cityofmilford.com

Certification of Medical Need

Name of City of Milford Customer: (*please print*)_____

Note to Customer:
The medical providers portion of this form MUST be filled out by a medical provider who is licensed in the State of Delaware.

When and if this form is approved it is only effective for 120 days, after that time a new certification must take place (every 120 days).

State of Delaware Code states: (http://delcode.delaware.gov/title26/c001/sc01/index.shtml)

(d) In no event shall such termination occur if any occupant of any dwelling unit shall be so ill that the termination of such sale or service shall adversely affect his or her health or recovery, which has been so certified by a signed statement from any duly licensed physician, physician assistant or advanced nurse practitioner, of this State or of a state with similar accreditation and received by any employee or officer of such person engaging in the distribution or sale of gas, water or electricity. Signed statements from a licensed physician, physician assistant or advanced nurse practitioner, obtained pursuant to this section are effective for 120 days. Signed statements may be renewed by means of a new signed statement to prevent termination only if a customer makes a good faith effort to make payments towards the utility service being provided. The Delaware Public Service Commission, may promulgate regulations defining "good faith effort to make payments". If a utility is subject to the jurisdiction of the Delaware Public Service Commission, that utility or a customer of the utility may petition the Delaware Public Service Commission for review of any dispute under this section. While such dispute is pending, a utility shall continue to provide utility service to the customer until a final Commission adjudication on the petition is issued. When possible no termination under this section shall occur without advance notice to any known case manager or coordinator of an occupant in an affected dwelling unit.

By signing this form I certify that the patient listed on the Medical Certification Form resides full-time at the address listed above.

I understand that in order for my request to be considered I must maintain any and all arrangements to satisfy my bill or it is subject to disconnect.

_____ _____
(Printed Name of City of Milford Customer) (Date)

_____
(Signature of person named above)

For internal use only:

Received by:_____Customer Account:_____

Date received:_____Valid through date_____

Medical Certification Form

I. Customer Information below **to be completed by the Customer ONLY**: (*Please type or print all information.)*

Name: _____ Account #: _____

Service Address: _____

Phone: _____

Patient's Name: _____ Relation to Customer: _____

City of Milford utility customer please read the following, **initial and sign**:

_____ • I certify that the patient named above is a member of my household residing at the above address.

_____ • I understand that this **Certification will expire 120 days** from the date shown and must be resubmitted to continue participation in the Medical Program.

_____ • I understand that this in no way releases me from my obligation to pay my monthly utility bill in accordance with the City of Milford defined payment terms.

Customer's Name: *(Print)* _____ *(Signature):* _____ Date: _____

II. Medical Information below **to be completed by a Delaware Licensed Healthcare Provider ONLY**:

I certify that I have examined the patient named above, in my professional opinion as a medical doctor, physician's assistant, nurse practitioner, or advanced-practice registered nurse licensed by the State of Delaware, I certify that it would be especially dangerous to my patient's health if the electricity is disconnected for the reason(s) marked below.

(CPAP machines for adult sleep apnea and small volume nebulizers **do not** qualify.)

_____ Nebulizer for Asthma/COPD	_____ Oxygen Concentrator	_____ **Infant** Apnea Monitor
_____ Heart Monitor	_____ Ventilator/Respirator	_____ Feeding (Pump)
_____ Home Dialysis Treatment	_____ Refrigeration for Insulin	_____ Other **(*)**

(*) A detailed explanation for reasons not mentioned above must be submitted for review. *(Please Print)* _____

_____

_____

_____

Is the medical equipment portable? ___Yes /_____No

Indicate the time frame for which the medical equipment will be required: ___

Number of amperes of power required to operate listed medical equipment: ___(AMPS).

(If the medical equipment requires more than 10 (AMPS), provide either: a copy of the medical equipment's specifications or the model name and number and the manufacturer's name and address).

Health Care Provider Name *(Print)*: _____ Office#: _____ Fax#: _____

Office Address: _____ City/State: _____ Zip Code: _____

Health Care Provider *(Signature)*: _____ Date: _____

Delaware Medical License Number: _____

**** Failure to complete this form in its entirety will result in a delay in processing and/or denied acceptance. ****

This **COMPLETED** form MUST be faxed or e-mailed from the office of the Delaware licensed healthcare provider to the City of Milford Customer Service at (302.422.1120) or (CustomerService@milford-de.gov). REV 04/20/2021