Medical Life Support (MLS) Application

Medical Discount Program

1. Account Information

Customer Name (as it appears on your MID bill)		
Service Address		
City		Zip Code
Mailing Address (if different than service address)		
City	State	Zip Code
MID Account Number	Contact Phone Number	

How to Apply

1. **Enter your account information.**
2. **Enter the household and income information.**
3. **Attach a copy of required documentation.**
4. **Have a physician complete the certification (page 2).**
5. **Sign and date the application. Return the application and required documents to:**

MID - MLS
P.O. Box 4060
Modesto, CA 95352-4060
or email to
MIDCares@mid.org

****Incomplete applications will not be processed****

2. Household Information & Income Verification

Total number of persons living in the home (full-time basis): Adults _____ + Minors (under 18) _____ = _____ Total

MID will no longer accept bank statements as proof of gross income. If you need a copy of your Social Security Award Letter, please contact the local Social Security office by calling **1-800-772-1213**. Documents will not be returned. Household income includes money from all household members (taxable or non-taxable), including but not limited to:

Wages $ _____	TANF (AFDC) $ _____	Spousal support $ _____
Interest income $ _____	Child support $ _____	Rent/royalty income $ _____
Social Security $ _____	Disability payments $ _____	Legal Settlements $ _____
SSI, SSP, SSDI $ _____	Workers compensation $ _____	Scholarships/Grants $ _____
Pensions $ _____	Unemployment benefits _____	Cash $ _____
	Self-employment income (Schedule C required) $ _____	

Other income (explain):_____ $

Total Monthly Household Income (Gross):	$	**Monthly household income must be $7,083 or less to qualify. Effective 01/01/2023**

3. Required Documentation

Please verify the following information is complete and attached:

☐ A complete month of income for all household members ☐ Complete Physician Certification

4. Declaration and Signature

MID cannot guarantee uninterrupted electric service. I am responsible for continuous electric service in the event of power outages or disconnection of service due to non-payment.

The information on this application and required documentation is used to determine and verify my eligibility for assistance. **All information is confidential and is not shared with outside agencies.** It is the customer's responsibility to contact MID if your household income increases above the current limits and/or if the patient no longer requires the medical device(s). MID reserves the right to request further certification at any time while the MID customer is on the program. Misrepresentation of information, failure to disclose all income or failure to provide additional documentation, including tax records, as requested by MID, may result in disqualification in the MLS program. MID will charge the customer the amount of the MLS discount inappropriately received in accordance with the MID Electric Service Rules.

If eligible for MLS discount, I permit the proper change to the rate schedule for the service address listed above and give consent to have my eligibility verified. I declare, under penalty of perjury, that the information on this application is true and correct.

X _____ _____

Signature (person whose name appears on MID bill) Date

Please have your physician complete page 2 (back page) of this application before mailing to MID.

For Physician Use Only

Page 2: To be completed by a Doctor of Medicine or Osteopath, licensed to practice in the State of California

1. Patient Information

Patient Name	Patient Date of Birth	Relationship to Customer

2. Life Support Device *(Electrically Powered)*

☐ **Yes** ☐ **No** **IPPB**

☐ **Yes** ☐ **No** **Oxygen Concentrator**

☐ **Yes** ☐ **No** **Electric Wheelchair**

☐ **Yes** ☐ **No** **In-Home Dialysis Cycler**

☐ **Yes** ☐ **No** **Other Equipment** *(description)*:_____

Devices used for therapy rather than life support do not qualify. Equipment must be plugged in and not battery operated.

3. Special Electric Heating and Cooling Needs

Medical discount is available for special heating and/or cooling needs if the patient is:

☐ Paraplegic ☐ Quadriplegic ☐ Hemiplegic ☐ Multiple Sclerosis ☐ Scleroderma

Heating or cooling is medically necessary to sustain the person's life or prevent deterioration of the person's medical condition:

☐ **Yes** ☐ **No** **Special Cooling Needs** *(description)*:_____

_____

☐ **Yes** ☐ **No** **Special Electric Heating Needs** *(description)*:_____

_____

4. Physician Certification *(MD or DO)*

Diagnosis / Medical Condition

I certify that the life support device(s) and/or additional heating or cooling will be required for a minimum of 12 months. Duration of medical condition:

Permanent (Check One) ☐ **Yes** ☐ **No** *Permanent: not expected to change for an indefinite time; not temporary.

Does interruption in power cause a potentially life-threatening medical condition? ☐ Yes ☐ No

Physician's Name	Phone Number
Office Address	City, State Zip Code
California Medical License Number	Fax Number
Physician Signature X	Date

MID Use Only

Approved ☐ **Yes** ☐ **No**

Recertification Required:

☐ Annually

☐ Every 3 Years

ES Staff Date

ES Supervisor Date

Reason for Disqualification:

☐ Equipment does not qualify

☐ Heating/Cooling needs do not qualify

☐ Income does not qualify

☐ Application Incomplete