Public Utility Commission of Texas
Application for Chronic Condition or Critical Care Residential Customer Status

IMPORTANT INFORMATION

- This Application must be completed in order to obtain the designation of Critical Care or Chronic Condition Status with your utility.
- **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, call the Customer's transmission and distribution utility (TDU) during normal business hours at the phone number below:

TDU:	Phone:	Fax:	Email Address:
AEP Texas Central	877-547-5513	361-880-6027	billing-dereg_texas@aep.com
AEP Texas North	877-547-5513	361-880-6027	billing-dereg_texas@aep.com
CenterPoint Energy	713-945-6353	713-945-6357	criticalcare-res@centerpointenergy.com
Nueces Electric	800-632-9288	361-387-4139	criticalcarereg@nueceselectric.org
Oncor	888-313-6862	800-666-3406	contactcenter@oncor.com
Texas-New Mexico Power	800-738-5579	469-484-8623	criticalcare@tnmp.com

- **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 customer at the mailing address provided.
- Pursuant to the rules of the Public Utility Commission of Texas, designation as a chronic condition or critical care residential customer does not relieve a customer 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:

- **Customer:** Complete PAGE 2 of this application, and provide to patient's physician for completion. **This application will not be approved unless submitted by fax or email by the physician to the applicable TDU.**
- **Physician:** After completing **PAGE 3** of the following pages, please forward only PAGES 2 and 3 to the Customer's TDU indicated on the form (using fax number or email address listed above).

PAGE 2 – To Be Completed by the Customer

PART 1: ALL INFORMATION IS REQUIRED

Customer 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 Customer.)

Service Address *(found on your electric bill)*

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

Mailing Address *(if different than Service Address)*

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

ESI ID *(found on your electric bill)*

TDU *(circle one based on first 7 numbers in the ESI ID):*	1020404 - - AEP TX North 1003278 - - AEP TX Central	1008901 - - CenterPoint 1017699 - - Oncor/SESCO	1013830 - - Nueces Elec Coop 1044372 - - Oncor 1040051 - - Texas New Mexico

Customer Primary Phone:	**Customer 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 the TDU 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):**

Customer:
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 Public Utility Commission 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 Customer.)

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

FROM PAGE 2:	
PATIENT'S NAME:	
CUSTOMER NAME:	ESI ID:

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 forward a faxed or electronic copy of the completed and signed application to the Customer's utility indicated in part 1 on page 2. See page 1 for utility fax and email addresses.