For Internal Use Only

Medical Baseline Allowance Application

(Used for Medical Baseline Allowance Program Enrollment and Recertification)

Part 1: To Be Completed by Customer (please print)

SDG&E® Customer Account #:					
Customer Name (as it appears on your bill):					
Patient's name (if different from customer):					
Service Address:		Unit/Space:		City:	
Customer Mailing Address (if different):					
Home Phone:	( )	Email address:			

For Customers Billed by Someone Other Than SDG&E:

Name of Mobile Home or Apartment Complex:			
Complex Address:		Unit/Space:	
Complex Manager's Name:		Complex Phone:	( )
Name of Tenant:		Tenant's Phone:	( )

How would you like to be contacted in case of planned or rotating power outages?

Select only one:

- ☐ Call me at the number below OR
- ☐ Send me a text message at the number below OR
- ☐ Contact me by TDD/TTY at the number below OR
- ☐ Email me at the address below

Number OR email:	

I understand that:

1. If the doctor certifies the resident's medical condition is permanent, SDG&E will require completion of a form self-certifying resident's continued eligibility for the Medical Baseline Allowance every two years.
2. If the doctor certifies the resident's medical condition is not permanent, SDG&E will require completion of a form self-certifying resident's continued eligibility for the Medical Baseline Allowance each year and completion of a new application with a doctor's certification every two years.
3. If the resident has a vision disability, I may contact SDG&E to request special notification when either recertification (to complete a new application with a doctor's certification) or self-certification forms are mailed.
4. SDG&E cannot guarantee uninterrupted gas and electric service and I am responsible for making alternate arrangements in the event of a gas or electric outage.

I certify that the above information is correct. I also certify that the qualifying resident lives full-time at this address and requires or continues to require the Medical Baseline Allowance. I agree to allow SDG&E to verify this information. **I also agree to promptly notify SDG&E if the qualified resident moves or the Medical Baseline Allowance is no longer needed by the resident. By signing below, I authorize SDG&E to share my customer information with other utilities and/or their agents to enable them to enroll me in other utility assistance programs.**

Customer Signature:		**Date:**	

The standard medical baseline allowance is 16.5 kilowatt-hours of electricity and/or 0.822 therms of natural gas per day, which is in addition to your daily standard baseline allocation. If this allowance does not meet your medical needs, please contact SDG&E at **1-800-411-7343** to discuss additional amounts.

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Part 2: To Be Completed by a Licensed Medical Doctor (M.D.) or Doctor of Osteopathy (D.O.)

I certify that the medical condition and needs of my patient (please print)**:**

Patient's Last Name:		First Name:	

1. Requires use of a life-support device* (check one) ☐ **Yes** ☐ **No**

The following life-support device(s) is(are) used in the above-named patient's home:

Device:		☐ Electricity	☐ Gas
Device:		☐ Electricity	☐ Gas
Device:		☐ Electricity	☐ Gas

*A qualifying life-support device is any medical device used to sustain life or is relied upon for mobility. This device must run on gas or electricity supplied by SDG&E. It includes, but is not limited to, respirators (oxygen concentrators), iron lungs, hemodialysis machines, suction machines, electric nerve stimulators, pressure pads and pumps, aerosol tents, electrostatic and ultrasonic nebulizers, compressors, IPPB machines, kidney dialysis machines, and motorized wheelchairs. **Devices used for therapy rather than life-support do not qualify.**

2. Requires heating and cooling:

The Medical Baseline Allowance is available for heating and/or cooling if the patient is paraplegic, quadriplegic, hemiplegic, has multiple sclerosis or scleroderma. The allowance is also available if the patient has a compromised immune system, life threatening illness or any other condition for which **additional heating or cooling is medically necessary to sustain the patient's life or prevent deterioration of the patient's medical condition.**

Requires the standard Medical Baseline Allowance for heating: (check one) ☐ **Yes** ☐ **No**

Requires the standard Medical Baseline Allowance for cooling: (check one) ☐ **Yes** ☐ **No**

3. I certify that the life-support device(s) and/or additional heating or cooling will be required for approximately:

(check one) ☐ **No. of Years** ________ **or** ☐ **Permanently**

MD or DO Name:		Phone No.:	( )
Office Address:			
MD/DO State License or Military License Number:			
Signature of MD or DO (not PA or NP):		Date:	

MAIL APPLICATION TO:

Medical Baseline Allowance Program Manager
San Diego Gas & Electric
P.O. Box 129831
San Diego, CA 92112-9831

Fax: 1-858-636-5749
Email: *medicalbaseline@sdge.com*

Some of these programs are funded by California utility customers and administered by San Diego Gas & Electric under the auspices of the California Public Utilities Commission.

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