



**Pacific Gas and
Electric Company™**

必須用英文填寫本表格

**醫療能源輔助計劃
申請表** 用於報名及重新確認

第1部份

由客戶填寫（請用英文端正填寫）

PG&E 帳戶號碼： _____

客戶姓名（帳單上的客戶姓名）： _____

申請者姓名（若不同的話）： _____

住址： _____

客戶郵寄地址（若不同的話）： _____

住宅電話：() _____ 工作電話：() _____

由流動房屋或公寓管理處開帳單的客戶

流動房屋或公寓大廈名稱： _____

大廈地址： _____

大廈負責人姓名： _____ 大廈電話：() _____

租客姓名： _____ 租客電話：() _____

本人瞭解：

1. 如果醫生證明該居民的健康狀況是永久性的，PG&E要求申請者每兩年填寫一份表格，自我證明本人或該居民繼續有資格享用醫療能源輔助。
2. 如果醫生證明該居民的健康狀況是非永久性的，PG&E要求申請者每年填寫一份表格，自我證明本人或該居民繼續有資格享用醫療能源輔助，並且每兩年填寫一份有醫生證明的新申請表。
3. 如果該居民有視力障礙，本人可以跟PG&E聯絡，要求寄來特別格式的重新確認表格（填寫有醫生證明的新申請表）或自我確認表格。
4. PG&E不能保證天然氣及電力供應服務不中斷，本人負責在天然氣中斷時或停電情況下作出替代安排。

本人證明以上資料正確無誤，並且證明申請醫療能源輔助者全天住在該地址，仍需要醫療額外能源津貼。本人同意允許PG&E核實本資料。**並且同意，如果合格的居民搬遷或該居民不再需要醫療額外能源津貼，立即通知PG&E。**

客戶簽名：_____ 日期：_____

標準醫療能源額外津貼為每天16.438度電力及／或 0.82192撒姆天然氣，這是你每天的標準底線配額之上的用量。如果該定量不能滿足你的醫療需要，請致電中文熱線1-800-893-9555跟PG&E聯絡，討論增加用量。

必須用英文填寫本表格

第2部份

由持照醫生 (M.D.) 或整骨醫師 (D.O.) 填寫

本人證明下列病人的健康狀況及需要（請用英文端正填寫）：

姓氏

名字

1. 需要使用生命維持設備* (選一個) 是 否

上述病人的家裡使用下列生命維持設備：

設備: _____ 電力 天然氣

設備: _____ 電力 天然氣

設備: _____ 電力 天然氣

* 合格的生命維持設備是指用於維持生命或依賴它來行動的任何醫療設備。該設備必須使用由PG&E供應的天然氣或電力。設備包括但不限於呼吸器（氧氣濃縮器）、鐵肺、血液透析機、抽吸機、電動神經刺激器、壓墊及壓泵、氣霧帷幕、靜電及超音波噴霧器、壓縮機、間歇正壓呼吸（IPPB）機、腎透析機及電動輪椅。用於物理治療而非維持生命的設備不合格。

2. 需要暖氣及冷氣 ::

如果病人患有截癱、四肢麻痺、偏癱、多發性硬化症或硬皮病，可申請額外能源開動冷氣或暖氣。如果病人缺乏免疫系統、患有危害生命的疾病或任何其他狀況，在醫療上必須有額外的暖氣或冷氣來維持病人生命或防止病人健康狀況惡化，亦可享用此計劃。

需要額外暖氣： (選一個) 是 否

需要額外冷氣： (選一個) 是 否

3. 本人證明該生命維持設備及／或額外暖氣或冷气的需要時間大約是：

(填寫一項) 年數 _____ 或 永久

醫生姓名： _____ 電話號碼： () _____

醫務所地址： _____

MD/DO 加州執照或軍隊執照號碼： _____

醫生簽名： _____ 日期： _____

FOR PG&E USE ONLY Date Received: _____ Medical Baseline Allocation: _____ Electric unit(s) _____ Gas unit(s)

Recertification: Self-certify every 2 years Self-certify annually; Doctor's certification every 2 years

將申請表寄到： *Pacific Gas and Electric Company, P.O. Box 8329, Credit & Records Center - Medical Baseline, Stockton, CA 95208*



**Pacific Gas and
Electric Company™**

THIS FORM MUST BE COMPLETED IN ENGLISH

**MEDICAL BASELINE ALLOWANCE
Application** *Used for Medical Baseline Enrollment and Re-Certification*

PART 1 TO BE COMPLETED BY CUSTOMER *(please print in English)*

PG&E Customer Account No: _____

Customer Name *(as it appears on your bill)*: _____

Medical Baseline Resident's Name *(if different)*: _____

Service Address: _____

Customer Mailing Address *(if different)*: _____

Home Phone: () _____ Work Phone: () _____

For Customers Billed by Someone Other Than PG&E

Name of Mobile Home or Apartment Complex: _____

Complex Address: _____

Complex Manager's Name: _____ Complex Phone: () _____

Name of Tenant: _____ Tenant's Phone: () _____

I understand that:

1. If the doctor certifies the resident's medical condition is permanent, PG&E will require completion of a form self-certifying continued resident's eligibility for Medical Baseline every two years.
2. If the doctor certifies the resident's medical condition is not permanent, PG&E will require completion of a form self-certifying continued resident's eligibility for Medical Baseline 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 PG&E to request special notification when either re-certification (to complete a new application with a doctor's certification) or self-certification forms are mailed.
4. PG&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 Medical Baseline resident lives full-time at this address, and requires or continues to require the Medical Baseline Allowance. I agree to allow PG&E to verify this information. **I also agree to promptly notify PG&E if the qualified resident moves or Medical Baseline Allowance is no longer needed by the resident.**

Customer Signature: _____ Date: _____

The Standard Medical Baseline Allowance is 16.438 kilowatt-hours of electricity and/or 0.82192 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 PG&E at 1-800-743-5000 to discuss additional amounts.

THIS FORM MUST BE COMPLETED IN ENGLISH

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 in English):

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 PG&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:

Standard Medical Baseline Allowances are available for heating and/or cooling if patient is Paraplegic, Quadriplegic, Hemiplegic, has Multiple Sclerosis or Scleroderma. Standard Medical Baseline Allowances are also available if 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 person's life or prevent deterioration of the person's medical condition.**

Requires Standard Medical Baseline Allowance for **heating**: (check one) **Yes** **No**

Requires 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:

(complete one) **No. of Years** _____ *or* **Permanently**

Doctor's Name: _____ Phone No. () _____

Office Address: _____

MD/DO California State License or Military License Number: _____

Signature of Doctor: _____ Date: _____

FOR PG&E USE ONLY Date Received: _____ Medical Baseline Allocation: _____ Electric unit(s) _____ Gas unit(s)

Recertification: *Self-certify every 2 years* *Self-certify annually; Doctor's certification every 2 years*

Mail application to: Pacific Gas and Electric Company, P.O. Box 8329, Credit & Records Center - Medical Baseline, Stockton, CA 95208