Los Angeles Department of Water & Power

APPLICATION FOR PHYSICIAN CERTIFIED ALLOWANCE DISCOUNT

INSTRUCTIONS:
1. Please print all information in capital letters using black or dark blue ink only.
2 Please have your Doctor complete the reverse side.
3. Mail completed application to: **Los Angeles Department of Water and Power**
Account Services Unit
PO Box 515407
Los Angeles, CA 90051-6707

LADWP Account Name:
Last Name | Initial
First Name

Service Address:
Street Number Only | Street Name
Apartment Number

City | State | Zip Code

Residence Phone Number:

Alternate Phone Number:

Patient's Name:
Last Name | Initial
First Name

IMPORTANT INFORMATION

1. This discount is available to any residential customer who provides verification by a state-licensed physician to the Department of Water and Power that a full-time resident of the premises served is a paraplegic, hemiplegic, quadriplegic, multiple sclerosis, neuromuscular, or scleroderma patient. The limited allowance is also available to an individual who has a compromised immune system, provided that a state-licensed physician certifies in writing to LADWP that an additional heating or cooling allowance, or both, is medically necessary in the person's full-time LADWP-serviced residence to sustain the life, or prevent deterioration, of the person's medical condition.
2. You may qualify for additional discounts. For information regarding our Life Support Device Discount, Senior Citizen or Disabled Citizen Lifeline Rate, please call us at (800) 342-5397.
3. Prior to approval, this application is subject to review by a Department of Water and Power medical doctor and will be reviewed periodically thereafter.
4. A new application must be filed with the Department when there is a medical status change or change of address.

AGREEMENT

I, the undersigned, as a customer of the Department of Water and Power (Department) in the City of Los Angeles, hereby claim eligibility and make application for the electric rate discount for paraplegic, quadriplegic, hemiplegic, multiple sclerosis, neuromuscular, scleroderma patient, or a person with a compromised immune system.

I understand that the individual who is a paraplegic, quadriplegic, hemiplegic, or a multiple sclerosis, neuromuscular, or scleroderma patient or a person with a compromised immune system, must be a full-time resident on the premises served.

I agree to notify the Department of any change in the above information.

All information contained in this application is true to the best of my knowledge. I understand that any misinformation could lead to disqualification for the discount.

Signature of LADWP Account Holder

Date M M - D D - Y Y Y Y

STATEMENT OF CERTIFICATION

To be completed by a Medical Doctor or Osteopath licensed to practice medicine in the State of California

PLEASE PRINT ALL INFORMATION LEGIBLY and ANSWER ALL QUESTIONS COMPLETELY

What is the patient's diagnosis? (If more than one, list all) _____

_____

_____

PHYSICIAN'S VERIFICATION

I hereby certify that (patient's name – First, MI, Last) _____

is a
- ☐ paraplegic (paralysis of lower half of the body with involvement of both legs)
- ☐ quadriplegic (paralysis of both arms and both legs)
- ☐ hemiplegic (paralysis of one side of the body)

has
- ☐ multiple sclerosis
- ☐ neuromuscular disorder
- ☐ scleroderma
- ☐ compromised immune system

Doctor's Name: Last Name _____ Initial _____

First Name _____ License Number: _____

Address: Street Number Only _____ Street Name _____

Apartment Number _____

City _____ State _____ Zip Code _____

Telephone Number: _____ Fax Number: _____

Doctor's Signature _____ Date M M - D D - Y Y Y Y

DWP USE ONLY

Account Number _____

DATE REC'D _____

DATE COMPLETED BY DEPARTMENT REPRESENTATIVE _____

APPROVAL ☐ YES ☐ NO	L/S?	EFFECTIVE DATE of DISCOUNT

Department Representative _____

Comments _____

_____

_____

_____