WOOD COUNTY
ELECTRIC CO-OP

A Touchstone Energy® Cooperative

P.O. Box 1827 • Quitman, Texas 75783 • Phone (903) 763-2203 • Fax (903) 763-5693 • www.wcec.org

RESIDENTIAL CRITICAL CARE NOTIFICATION & ELIGIBILITY DETERMINATION FORM

This form must be completed and returned to the cooperative, by the petitioner, for consideration of placement on the critical care list. Please address the returned form to Tommy Brown, Director of Member Relations, P.O. Box 1827, Quitman, Texas, 75783.

Annual renewal is required to remain on the critical care list.

Residential Critical Care consumers meet a minimum of the following two requirements:

1.) The member has medical equipment with electric or battery backup.
2.) Equipment is required 24 hours a day to sustain life.

While the cooperative strives to provide uninterrupted service, circumstances beyond our control cause unplanned outages of varying duration, thus rendering it impossible to guarantee uninterrupted service. Therefore, it is imperative and incumbent upon each individual classed as a critical care case to make adequate backup plans in the event of an outage that may include: backup battery power, use of a generator, or relocation to a site that can serve the health needs of that individual.

In the event of an unplanned outage affecting critical care customers, and depending on the nature and duration, the cooperative will make a reasonable effort to notify individuals via telephone or visitation if possible.

I, the undersigned, have read the above and understand that the cooperative accepts no liability for interrupted power supply and that I am responsible for securing adequate provisions in the event of an outage.

Member Name: _____

Member Signature: _____

Date: _____

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RESIDENTIAL CRITICAL CARE ELIGIBILITY DETERMINATION FORM

This section to be completed by Wood County Electric Cooperative

Member Number: _____

Member Name: _____

Service Address: _____

Date Form Received by Member: _____

This section to be completed by Member

Patient Name (please print): _____

Telephone Number: Home: _____ Other: _____

Secondary Contact Name: _____

Relationship: _____

Phone Number for Secondary Contact: _____

Patient's Signature: _____ Date: _____

This section to be completed by Patient's Physician

Physician Name: _____

Physician Address: _____

Physician Phone Number: _____

Medical Equipment Information

Type of Electric, Life Sustaining Equipment Used: _____

Does member require on-site back-up capabilities or other alternatives for loss of normal electrical service?
(circle one) Yes No

If Yes, please describe: _____

How long can patient sustain without electrical service? (number of hours): _____

Is condition life threatening without electrical service? (please circle one): Yes No

Physician's Signature: _____ Date: _____

This qualification requires renewal one year from the date qualified. The information on this form may be subject to verification and additional information may be required from you or your physician.

Qualification pursuant to this form does not guarantee uninterrupted power supply, and if electricity is a necessity, you should have backup arrangements in place.