Village of Arcade - Billing Department
17 Church Street • Arcade • NY • 14009
(585) 492-1111• phone

Date: _____

Return within 10 days of date shown above

MEDICAL CONDITION CERTIFICATION

Any certification of a medical emergency shall be submitted on this form. The certificate shall be effective for 30 days from the date the Village of Arcade (VOA) receives the certification. The VOA will not terminate electric service when a medical emergency as certified by a medical provider exists and the customer demonstrates their inability to pay charges for service. Before a certification of medical emergency can be renewed an Assets/Income and Expense Request Form must be completed and returned to the VOA.

Complete Part 1 - Customer Information. Have your medical provider complete Part 2 Medical Provider Information and return the completed form to the VOA at the address above.

If a medical emergency no longer exists complete Part 1 - Customer Information and be sure to check the box stating that the medical condition certificate previously on file with the VOA is no longer applicable and return to the VOA.

Part 1 - Customer Information

NOTICE: If your name, address, or medical condition changes, you MUST inform the Village of Arcade.

Account Number:	Utility Customer Name:
Utility Service Address:	Mailing Address, if different:
Daytime Phone:	Evening Phone:
Name of resident with qualifying medical condition:	
Relationship to the utility customer:	
[ ] Check this box, if the medical condition certificate previously on file with the Village of Arcade is no longer applicable. Sign, date, and return this form to the Village of Arcade at the address above.	
My signature gives consent for this information to be shared with the Village of Arcade, Department of Social Services, or the New York State Public Service Commission. I declare, under penalty of perjury, that the information I provided on this form is true and correct. Signature Date	

Part 2 - Medical Provider Information

Medical Provider's Name:	Title/Specialty:	
Organization:	Phone:	State Registration #:
Office Address:		
List the medical condition(s) for the patient listed above that requires electric service for his/her condition:	[ ] chronic condition [ ] temporary condition. If temporary, expected recovery date:	
[ ] Life sustaining equipment [ ] Space conditioning	List any electrically powered medical equipment required for this patient:	
Would the interruption of electric service significantly aggravate the medical condition or emergency situation at this service location? If yes, can the equipment be used at another location where electric service is available?		

I declare, under penalty of perjury, that the information I provided on this certification form is correct and true.

_____
Medical Provider Signature Date

FOR OFFICE USE ONLY
[ ] Date received stamped
[ ] Comment code added to customer account
[ ] Archive comment report
[ ] Renewal & inc/exp due
_____