Life Sustaining Medical Hardship Certification
Gallatin Department of Electricity (GDE)

Instructions:

The following is to be completed by a licensed medical professional and only after you or someone in your office has examined the individual whose name appears as the patient on the form below. This form applies only in situations where, in your professional opinion, termination of electricity service would be especially dangerous to the health of this individual. If, in your professional opinion, an especially dangerous situation does not exist, please do not sign this form. If you have any questions regarding this form, please contact the Gallatin Department of Electricity at 615-452-5152.

Please fax the completed form to GDE at 615-452-6060 or email to customerservice@gallatinelectric.com.

I certify that, to the best of my knowledge, the information provided below is true.

The following medical information must be certified by one of the following. Please indicate if you are a:

☐ Licensed Physician ☐ Physician's Assistant ☐ Clinical Nurse Specialist

☐ Certified Nurse Practitioner ☐ Local Board of Health Physician

Please complete the following: (Please print)

I certify that my patient has been examined by me and I have determined the following to be true:

Name of patient: _____

Patient's permanent residence: _____

_____

Check the box that applies:

☐ This patient suffers from a life threatening medical condition and termination of electric service would be especially dangerous or life threatening.

☐ This patient uses medical or life-supporting equipment and termination of electric service would make operation of that equipment impossible or impractical. Equipment: _____ **Check length of certification:**

☐ One (1) month ☐ Three (3) months ☐ Six (6) months ☐ One (1) year

I certify that I have advised my patient that disclosure of the requested information may be subject to redisclosure by the recipient and no longer protected by the HIPAA rules and regulations.

Authorized Signature: _____

Date: _____

Name of Licensed Medical Professional: _____

Business Address: _____

Business Phone Number: _____

Current State License or Certificate Number: _____

Note: The customer of record at the residence above must also fill out a GDE form for this certification to be officially recorded at GDE. This Certification does not guarantee continuous supply of electricity. GDE shall not be liable for loss of electric service for reasons beyond GDE control. GDE's Rules & Regulations still apply to this individual. The individual may still be subject to disconnection of service due to a non-pay situation after a special extended period of partially limited electric service for 15 days in addition to the normal grace period. If at all possible GDE will make special consideration to quickly restore electricity to patient's permanent residence when an outage occurs.

Life Sustaining Medical Hardship Certification
Customer Verification Form Gallatin
Department of Electricity (GDE)

Instructions:

The following form must be filled out by the **Customer of Record** and the **Patient** at the residence where the medical hardship patient resides. Please fill out all information and sign to verify.

Patient Name: _____

Patient's Permanent Residence: _____

_____

Patient's phone number _____

Patient's Licensed Medical Professional: _____

Medical Professional's Phone Number: _____

Patient or Guardian: I hereby attest I am a full-time permanent resident of the address listed above and that this application for a Life Sustaining Medical Hardship is valid and that complete termination of electric service would endanger my life. I acknowledge that this certification, if approved, does not preclude GDE's right to partially limit electric service at the service address listed above and to pursue collection avenues for the recovery of unpaid billings, or to disconnect service under GDE's Rules & Regulations. I agree to pay GDE for all costs and expenses of all acts taken for collection of unpaid billings. **GDE will not notify Patient when this certification needs renewal.**

Signed: _____

Date: _____

Customer of Record: I hereby attest I am the Customer of Record at the above address and that the Patient named above permanently resides within my residence. I further attest that I have read and understand Gallatin Department of Electricity's Rules and Regulations as they apply to Documented Life Sustaining Medical Hardship and that this account may still be subject to disconnection for violation of GDE's Rules and Regulations. I am responsible for the payment of the GDE billings for electric service at the Service Address shown on this certification, and attest that this certification is a valid medical hardship and not an attempt to avoid payment for services provided. I hereby agree to pay all billings promptly and acknowledge that this certification, if approved, does not preclude GDE's right to partially limit electric service at the service address listed above and to pursue collection avenues for the recovery of unpaid billings, or to disconnect service under GDE's Rules & Regulations. I agree to pay GDE for all costs and expenses of all acts taken for collection of unpaid billings. **GDE will not notify Customer of Record when this certification needs renewal.**

Signed: _____

Date: _____

Print Name: _____

Address: _____

_____

Account Number: _____ GDE Approved: _____ Date: _____

I have received a copy of GDE's Rules & Regulations. Signed: _____ Date: _____