



National
Consumer Law
Center
*Fighting Together
for Economic Justice*

<http://bit.ly/ill-consumer-utility>

PROTECTING SERIOUSLY ILL CONSUMERS FROM UTILITY DISCONNECTIONS

WHAT STATES CAN DO TO SAVE LIVES NOW

APPENDIX F

REQUIREMENTS FOR DOCUMENTATION OF SERIOUS ILLNESS AND SAMPLE FORMS*

Following are sample forms of states that have effective language to document serious illness.

Arkansas

Ark. Admin. Code § 126.03.2-6.17(D).

D. Physician's Certificate

A completed physician's certificate must be signed by a physician and must be in the following form. The utility shall provide a copy of the physician's certificate form to the physician.

PHYSICIAN'S CERTIFICATE OF MEDICAL NEED FOR UTILITY SERVICE

The Arkansas Public Service Commission requires utilities under its jurisdiction to honor physician's certificates which attest to the fact that a utility customer or any permanent resident of the household has a serious medical condition. The certificate must clearly state that the suspension of utility service would give rise to a substantial risk of death or gravely impair the health of the customer or another permanent household resident.

A licensed physician or other health care professional providing health care services to the patient may notify the utility of the serious medical condition. The notice must be followed within 7 days by a certificate. The certificate is valid for up to 30 days and may be extended for one additional 30 day period by reverification by the physician or health care professional prior to the expiration date of the first certificate. This reverification requires that an additional certificate be submitted to the utility.

*These forms are the most recent available. For updates, please consult the utility company or state utility commission

You are being asked to verify that the stated condition exists. This certificate allows the utility customer time to secure payment for utility service or to make alternate arrangements for care of the patient.

Thank you for your cooperation.

To: _____
(Name of Utility) Date

I certify that loss of utility service would give rise to a substantial risk of death or gravely impair the health of who lives at

_____.

The nature of the serious medical condition is

_____.

The effect of loss of utility service would be

_____.

This condition is expected to continue _____ days.

I am licensed to practice medicine by the Arkansas State Medical Board or a comparable licensing authority in the State of _____.

Physician _____

Address _____

Phone number _____

Idaho

Idaho Admin Code r. 31.21.01.308.01.

The certificate must contain the following information:

- a. A statement that the customer, a member of the customer's family, or other permanent resident of the premises where service is rendered is seriously ill or has a medical emergency or will become seriously ill or have a medical emergency because of termination of service, and that termination of utility service would adversely affect the health of that customer, member of the customer's family, or resident of the household.
- b. The name of the person whose serious illness or medical emergency would be adversely affected by termination and the relationship to the customer, and
- c. The name, title, and signature of the person certifying the serious illness or medical emergency.

Illinois

Ill. Admin. Code tit. 83, § 280.160(d).

d) Certificate Content:

- 1) Name and contact information for the certifying party;
- 2) Service address and name of patient;
- 3) A statement that the patient resides at the premises in question; and
- 4) A statement that the disconnection of utility service will aggravate an existing medical emergency or create a medical emergency for the patient.

Maine

Me. Admin. Code 65-407 ch.815, §11(C).

The utility may require that a written certification include the following if the utility provides a form for the physician to complete:

1. The name and service location of the customer (to be provided by the utility).
2. The name and address of the person with the medical emergency.
3. A statement that a serious illness or medical condition exists which would be seriously aggravated by lack of utility service.
4. The anticipated length of the medical emergency.

5. The specific reason why continued service is required.
6. The name, office address, telephone number and signature of the certifying physician.

Massachusetts

220 Mass. Code Regs. § 25.03(2)(a).

Said certificate shall state the name and address of the seriously ill person, the nature of the illness and the business address and telephone number of the certifying physician, physician assistant, nurse practitioner or local board of health;

Sample template for Serious Illness letter
(no official form required to document illness):

To Whom It May Concern:

[Name of patient] who resides at [address] is a patient of mine [or: is under my care].

[Name of patient] is being treated for [describe illness or condition], a serious illness.

Sincerely,

[Health professional's name and contact information]

Sample template for Serious Chronic Illness letter
(no official form required to document illness):

To Whom It May Concern:

[Name of patient] who resides at [address] is a patient of mine [or: is under my care].

[Name of patient] is being treated for [describe illness or condition], a chronic illness.

Sincerely,

[Health professional's name and contact information]

Montana

Mont. Admin. R. 38.5.1411.

All certifications must be in writing and provide the name and address of the person with the medical condition that would be aggravated by a termination of service. The certification must include the printed name, signature, office address, and telephone number of the certifying licensed health care professional.

Ohio

Ohio Admin. Code 4901:1-18-06(C)(3)(b).

(b) The certification of the medical condition or the need for the medical or life-supporting equipment required by paragraph (C)(1) of this rule shall be in writing and shall include the name of the person to be certified; a statement that the person is a permanent resident of the premises in question; the name, business address, and telephone number of the certifying party; a statement of the need for the medical or life-supporting equipment, if applicable; and a signed statement by the certifying party that disconnection of service will be especially dangerous to the health of a permanent resident of the premises.

PUCO Sample form (see next page).

30-Day Medical Certification

(Name of Utility Company)

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 (gas/electric/water) utility service would be especially dangerous to the health of that 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: (utility company name and phone number). You may fax the completed form to us at (fax number).

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:

- | | |
|--|--|
| <input type="checkbox"/> licensed physician | <input type="checkbox"/> physician assistant |
| <input type="checkbox"/> clinical nurse specialist | <input type="checkbox"/> certified nurse practitioner |
| <input type="checkbox"/> certified nurse-midwife | <input type="checkbox"/> 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: (street address) _____
(city, state, zip code) _____

Check the box of the applicable condition:

- This patient suffers from a hazardous medical condition and termination of (gas/electric/water) utility service would be especially dangerous or life-threatening.**
- This patient uses medical or life-supporting equipment and termination of (gas/electric/water) utility service would make operation of that equipment impossible or impractical.**

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

Authorized Signature _____

Date _____

(Please Print)

Name of Licensed Medical Professional _____

Business Address _____

Business Telephone _____

Current State License or Certificate Number: _____

All sections must be fully completed in order to process the medical certification request.