Heart of Texas Electric Cooperative, Inc.

CRITICAL CARE ELIGIBILITY DETERMINATION FORM

TO BE COMPLETED BY CUSTOMER

Customer Information

Name on Account: _____

Account Number: _____

Patient Name: _____

Service Address: _____

Telephone Number: Home_____ Work_____

Secondary Contact: _____

Relationship: _____ Phone Number: _____

Does customer have on-site back-up capabilities or other alternatives for loss of normal electrical service?

_____If yes, describe: _____

_____

Patient's Signature: _____ Date: _____

*Chronic condition or critical care status does not guarantee an uninterrupted, regular, or continuous power supply. If electricity is a necessity, you must make other arrangements for on-site back-up capabilities or other alternatives in the event of loss of electric service.

TO BE COMPLETED BY PHYSICIAN

Physician Information

Physician Name: _____

Physician Address: _____

Physician Phone Number: _____

Medical Equipment Information

Type of Electric, Life Sustaining Equipment Used: _____

Medical Diagnosis: _____

How long can patient be sustained without electrical service? _____

Is condition life threatening without electrical service? _____

Physician's Signature: _____ Date: _____

Please Return To: HEART OF TEXAS ELECTRIC
PO BOX 357
MCGREGOR TX 76657
254-840-2871