



Application for Critical Residential Account Status

Important Information

- This application must be completed in order to obtain the designation of Critical Residential Account.
- **This application will not be processed and approved if incomplete, unreadable or improperly submitted.** All information is required, unless otherwise indicated.
- Submission of this application does not automatically result in Critical Residential Account status. Notification of the status granted will be provided to the Customer at the mailing address provided.
- Designation as a Critical Residential Account does not relieve a customer of the obligation to pay for electric service, and service may be disconnected for failure to pay.
- **Critical Residential Account 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.

Instructions

- **Customer:** Complete **PAGE 2** of this application, and provide to patient's physician for completion. **This application will not be approved unless submitted by fax or email by the physician.**
- **Physician:** After completing **PAGE 3**, please forward only **PAGES 2** and **3** to CoServ.

Page 2–To Be Completed by the Customer

PART 1: ALL INFORMATION IS REQUIRED

Customer Name:
(Name on electric account)

Patient Name:

(Name of patient who is living permanently at the Service Address, and who needs critical care or chronic-condition status. The patient may be the same person as the Customer.)

Service Address:

City:

State:

Zip:

Mailing Address (If different):

City:

State:

Zip:

Account Number:

Customer Primary Phone:

Customer Alternate Phone (If any):

Emergency (secondary) Contact Information *(Your application will be rejected unless you include an emergency contact name or insert "I choose not to provide an emergency contact name." Failure to include an emergency contact may result in disconnection of your electric service without notice if we are unable to contact you and your electric bill is overdue.)*

Emergency Contact Name:

Mailing Address (If different):

City:

State:

Zip:

Emergency Contact Phone:

Emergency Contact Alternate Phone (If any):

Customer:

I have read and understood the information and certify that the information provided on this application is correct. I understand the information may also be used to determine whether I am eligible for additional notices and other protections relating to my electric service available under Public Utility Commission rules, and may be used to provide notices relating to my electric service to the Emergency Contact.

Customer Signature:

Date:

Patient/Patient's Guardian, Parent or Managing Conservator:

I have read and understood the information and certify that the information provided on this application about me (or the patient) is correct. I agree to the release of the information on this form concerning my (or the patient's) medical condition for the purposes stated on this application.

Patient Signature:

Date:

Page 3–To Be Completed by the Patient’s Physician

FROM PAGE 2:	
Patient Name:	
Customer Name:	Account Number:

PART 2: ALL INFORMATION IS REQUIRED		
Option 1:	Yes	No
The patient is dependent upon an electric-powered medical device to sustain life.		

–AND/OR–		
Option 2:	Yes	No
The patient has a serious medical condition that requires an electric-powered device or electric heating or cooling to prevent impairment of a major life function through a significant deterioration or exacerbation of the person’s medical condition.		
If you answered yes to option 2, has the above medical condition been diagnosed as a life-long condition?		

Physician Name: <i>(printed)</i>	
Texas Medical Board License Number:	
Phone:	Fax:
Physician Signature:	Date:

After completing the application, please forward a faxed or electronic copy of the completed and signed application to CoServ at contact@coserv.com or (940) 270-6640.