BAILEY COUNTY ELECTRIC COOPERATIVE ASSOCIATION

Touchstone Energy® Cooperatives

CRITIAL CARE APPLICANT INFORMATION		
Member Name:		
Name of person requiring Critical Care status:		
Service Address:		
Mailing Address:		
City:	State:	ZIP Code:
Phone:	Cell Phone:	Email:
Member Number:	Account Number:	Meter Number:
EMERGENCY CONTACT		
Name of a relative not residing with you:		
Address:		Phone:
City:	State:	Zip Code:
Phone:	Cell Phone:	Relationship:
AUTHORIZED AGENT ON ACCOUNT		
Name:		
Primary Phone:	Secondary Phone:	Email:
MEDICAL NECESSITY (MUST BE VERIFIED BY LISCENSED PHYSICIAN ON HIS/HER PROFESSIONAL LETTERHEAD)		
Electric-powered Medical Device:		
Is the patient dependent upon an electric-powered medical device to **sustain life**? No Yes *(circle one)*		
Does the patient have a serious medical condition that requires electricity or a specific electric-powered medical device to prevent **impairment of a major life function** through a significant deterioration or exacerbation of the person's medical condition? No Yes *(circle one)*		
The above medical condition has been diagnosed as a **life-long condition**? No Yes *(circle one)*		
Name of Physician:		
City:	State:	Zip Code:

My signature below is certification that the information contained in this application is true and correct. I understand that the information may be used to determine my eligibility for the BCEC Medical Critical Care registry. I certify that the person covered by medical critical care is a **permanent resident at the above service address**.

_____ _____ _____

Member Signature Printed Name Date