**City of Santa Clara**
**Medical Rate Assistance Program**
1500 Warburton Avenue
Santa Clara, CA 95050
408-615-2300
1-800-735-2922 CA Relay Service

**PLEASE KEEP THIS INFORMATION SHEET**

(408) 615-2300, Municipal Services Division
Monday - Friday, 8:00 a.m. - 5:00 p.m.
1-800-735-2922 CA Relay Service for the Deaf/Hearing Impaired

**PROVIDE ALL REQUESTED INFORMATION SO THERE WILL BE NO DELAY IN PROCESSING YOUR APPLICATION.**

## YOU MAY BE ELIGIBLE FOR THE CITY OF SANTA CLARA'S MEDICAL RATE ASSISTANCE PROGRAM (M.R.A.P.), IF:

- You are a City of Santa Clara residential customer and pay your energy bill directly to the City of Santa Clara and,
- You have a medical condition that requires a high usage electric device prescribed by a physician, or
- You have a disability condition that requires a high usage electric device prescribed by a physician, and
- You have submitted a completed Physician's Certification Form. This must be re-certified every two years.
- Applicants who qualify for both the Low Income and Medical Rate Assistance programs will be enrolled in the Medical program, only.
- The discount will be 25% from the electric portion of your utility bill. All other services will be billed at the regular rates.

*Please note: The City of Santa Clara does not discriminate in the provision of services on the basis of race, color, creed, national origin, gender, sexual orientation,age, disability, religion,ethnic background, or marital status.*

*(17/09/27)*

# APPLICATION FOR
# Medical Rate Assistance Program
# Municipal Services Division
# City of Santa Clara
# 1500 Warburton Avenue
# Santa Clara, CA 95050

**(408) 615-2300: Monday - Friday, 8:00 a.m. - 5:00 p.m.**
**1-800-735-2922 CA Relay Service for the Deaf or Hearing Impaired**

The City of Santa Clara provides a Medical Rate Assistance Program (M.R.A.P.). This program provides a monthly 25% discount to eligible households on their municipal utilities electric charges. To participate in M.R.A.P., you must submit a completed Physician's Certification Form. Please note that applicants who qualify for both the Low Income and Medical Rate Assistance programs will be enrolled in the Medical Rate Assistance program only.

**Notice: If your name, address, or medical condition changes, you MUST inform the City of Santa Clara, Municipal Services Division**

**Name of Utility Customer**

| First | Middle | Last | Electric Utility Account No. |
|---|---|---|---|
| | | | |

**Name of Resident with Qualifying Medical Condition**

| First | Middle | Last | Relationship to the Utility Customer: |
|---|---|---|---|
| | | | ___ Self ___ Child<br>___ Spouse ___ Other _____ |

**Mailing Address**

| Number and Street | | Apt No. | Attention |
|---|---|---|---|
| | | | If you use a medical device such as an oxygen machine or ventilator, please notify the Santa Clara Fire Department at: (408) 615-4900 for protective services in the event of an emergency. |
| City | State | Zip Code | |
| | | | |

| Email Address: | Daytime Phone Number: |
|---|---|
| | |

The information on this application will be used to determine and verify my eligibility for assistance. My signature gives consent for this information to be shared with other offices of the State and Federal Government and with my utility company as necessary to effectuate the purpose of this application. If eligible for the M.R.A.P. discount, I permit the proper change to my rate schedule and, if needed, give consent to have my eligibility verified every two years. I declare, under penalty of perjury, that the information on this application is true and correct.

X_____

Applicant's Signature Date Witness' Signature (If applicant signed with a mark)

**YOU MUST INCLUDE THE FOLLOWING!!!**

- ❑ **This form filled out completely**
- ❑ **Your utility account number**
- ❑ **Completed Physician Certification Form**

**SANTA CLARA OFFICIAL USE ONLY**

**Verified by** _____

**Date** _____

For information on the Home Energy Assistance Program, call Community Action at 1-866-205-2388 or 408-920-3953.

# Physician's Certification Form
# Medical Rate Assistance Program

Municipal Services
City of Santa Clara
1500 Warburton Avenue
Santa Clara, CA 95050

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**I Certify That:**

Name of Patient**:** _____
(First, Middle, Last)

Patient's Santa Clara Address:_____
(Street, City, Zip Code)

This certification will be used to evaluate the patient's eligibility for participation in the City of Santa Clara's Medical Rate Assistance Program. Applicants who are prescribed a high usage electric device by a physician for treatment of a medical condition or disability must provide a physician's certification form documenting the patient's needs and requirements for an electric device for treatment. For example, paraplegic, hemiplegic, or quadriplegic people qualify. Similarly, a scleroderma patient with special heating or cooling needs qualifies, as do residents dependent upon life support equipment.

Please list the patient's medical condition(s) that requires a high usage electric device. An electric device is defined as any device prescribed by a physician that consumes above and beyond normal energy consumption. This definition includes any prescribed durable medical equipment and/or a space conditioning device. Please list the electric device prescribed for this patient's treatment and the duration the patient will need the device. If the patient requires multiple devices, please provide the duration of each.

| Prescribed Electric Device | Start Date | End Date (Estimated) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Doctor's Name _____
(First, Middle, Last)

Office Address _____
(Street, City, Zip Code)

CA Physician License No._____ Telephone No. _____

This information will be used the City of Santa Clara to determine eligibility for the Medical Rate Assistance Program.
I declare, under penalty of perjury, that all the information on this certification form is correct and true.

_____ _____
Physician's Signature Date