BROWNSVILLE
PUBLIC UTILITIES BOARD

Life Support Alert Application

- **Submission of this application does not automatically result in chronic condition or critical care status. This form will not be processed if incomplete, unreadable, or improperly submitted. All information is required, unless otherwise indicated.**
- **Designation as a chronic condition or critical care residential customer does not relieve a customer of the obligation to pay for electric service, and service may be disconnected for failure to pay.**
- **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.**
- **It ls the customer's responsibility to inform BPUB of any updates to their contact information primarily most current phone number and mailing address.**
- **The submitted application is only valid until June 1st and must be renewed on an annual basis.**
- **For the purpose of this application, the term "physician" shall mean an authorized practitioner of medicine as one graduated from a college of medicine or osteopathy and licensed by the appropriate board.**
- **For questions about this form, please call the Brownsville Public Utilities Board at 956-983-6134 during normal business hours.**

INSTRUCTIONS:

- **Customer:** Complete **PAGE 2** of this application and provide to patient's physician for completion and submission. **This application will not be processed unless submitted by fax or email by the physician to BPUB.**
- **Physician:** After completing **PAGE 3** of this application, please forward only Pages 2 and 3 to BPUB as indicated on the form (using fax number or email address listed on page 3).

PAGE 2 – To Be Completed by the Customer

PART 1: ALL INFORMATION IS REQUIRED

Customer Name:
(Name on electric account)

BPUB Account #:
(6 digits found on your bill)

Patient's 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:
(Found on your electric bill)

State: **ZIP**

Mailing Address:
(if different)

State: **ZIP**

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 BPUB is unable to contact you and your electric bill is overdue.)**

Name of Emergency Contact:

Phone:	**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 Brownsville Public Utilities Board rules, and may be used to provide notices relating to my electric service to the Emergency Contact.

Signature: **Date:**

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

I have read and understood the information and certify that the information provided in 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.

Signature:
(Signature required, even if same person as Customer)

Date:

PAGE 3 – To Be Completed by the Patient's Physician

FROM PAGE 2:	
Patient's Name	
Customer's Name	Customer Address

Part 2: ALL INFORMATION IS REQUIRED

Option #1	**YES**	**NO**
1)The patient is dependent upon an electric-powered medical device **to sustain life**.		

-AND/OR-

Option #2	**YES**	**NO**
2) The patient has a serious medical condition that requires an electric-powered medical 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.		
a) If yes to Option #2 above, has the above medical condition been diagnosed as a life-long condition?		

Physician Name: (printed)	
Texas Medical Board License Number:	
Phone:	**Fax:**
Physician Signature:	**Date:**

This application will not be processed unless submitted by fax or email by the physician to BPUB.

After completing this Application, please forward a faxed or electronic copy of the completed and signed application to BPUB:

Email: Collections@brownsville-pub.com
Fax# (956) 214-4000 or (956) 214-4001