Xcel Energy®

PLEASE NOTE: To be complete, ALL fields must be filled in, valid, and legible.

FINANCIAL CERTIFICATION (VALID FOR 90 DAYS ONLY)

BY SIGNING BELOW, I, THE ACCOUNT HOLDER, ACKNOWLEDGE THAT THIS CERTIFICATE DOES NOT RELIEVE ME OF MY RESPONSIBILITY TO PAY MY CURRENT AND PAST BILLS WITH (NAME OF UTILITY).

- **For Administering Authority (Human Services Department (HSD) or Tribal Authority) certification: complete Sections I and II.**

OR

- **For self certification: complete Section III and attach a copy of the primary account holder's current Medicaid eligibility.**

(Even when Extended Medical Certification is authorized, Financial Recertification is required every 90 days for the Account Holder.)

SECTION I : AUTHORIZATION TO RELEASE INFORMATION - PRIMARY UTILITY ACCOUNT HOLDER

I, _____, authorize Administering Authority to release to (name of utility) information from
PRINTED NAME OF PRIMARY ACCOUNT HOLDER
my file as deemed necessary for the purpose of qualifying for the Medical Certification program.

I certify the information provided is true and correct. I understand that if I provide false information, I can be denied continued medical emergency gas or electric utility service.

PRIMARY ACCOUNT HOLDER'S SIGNATURE	**UTILITY ACCOUNT NUMBER**	**PRIMARY ACCOUNT HOLDER'S SOCIAL SECURITY NUMBER**

PRIMARY ACCOUNT HOLDER'S TELEPHONE NUMBER	**SERVICE ADDRESS**	**CITY**	**STATE**	**ZIP CODE**

SECTION II - ADMINISTERING AUTHORITY (HSD OR TRIBAL) USE ONLY

I _____, an authorized representative of _____ hereby certify that
NAME OF AGNECY REPRESENTATIVE **ADMINISTERING AUTHORITY**

_____, the primary account holder named in Section I **currently meets the income guidelines** as defined by the Administering Authority (such as Low Income Home Energy Assistance Program (LIHEAP) assistance).
PRIMARY ACCOUNT HOLDER AND SOCIAL SECURITY NUMBER

AGENCY REPRESENTATIVE SIGNATURE	**CONTACT NUMBER AND FAX NUMBER**	**DATE**

- OR -

SECTION III —SELF CERTIFICATION - PRIMARY ACCOUNT HOLDER - ATTACH COPY OF CURRENT NEW MEXICO MEDICAID ELIGIBILITY FOR PRIMARY ACCOUNT HOLDER

I, _____ hereby certify that I am the person responsible for the charges for gas or electric
PRINTED NAME OF PRIMARY ACCOUNT HOLDER

utility service at _____and that a seriously or chronically ill person (as defined by Rule 17.5.410.7
SERVICE ADDRESS

NMAC) _____ resides there.
PATIENT'S NAME

I certify the information provided is true and correct. I understand that if I provide false information, I could be denied continued medical emergency gas or electric utility service.

PRIMARY ACCOUNT HOLDER SIGNATURE	**DATE**	**PRIMARY ACCOUNT HOLDER'S SOCIAL SECURITY NO.**

SERVICE ADDRESS	**CITY**	**STATE**	**ZIP CODE**

It is in the account holder's best interest to make regular payments toward current and past due balances; the account holder is encouraged to contact (name of utility) to make payment arrangements.

SEE OTHER SIDE FOR MEDICAL CERTIFICATION

PLEASE NOTE: To be complete, ALL fields must be filled in, valid, and legible. SC044-4-4 *

MEDICAL CERTIFICATION

NOTE: In order to continue to receive gas or electric service from (name of utility), a complete Medical and a complete Financial Certification Form must be submitted. This certification is valid for ninety (90) days from the signature date of medical professional.

PATIENT OR LEGAL GUARDIAN

I certify the information provided is true and correct. I understand that if I provide false information, I could be denied continued medical emergency gas or electric utility service from _____.
Name of Utility Company

I, _____, hereby authorize the medical professional signing this certification to
PRINTED NAME OF PATIENT
disclose to _____ the information contained in this Medical Certification Form.
Name Of Utility Company

_____ _____
PATIENT OR LEGAL GUARDIAN SIGNATURE DATE

PRIMARY UTILITY ACCOUNT HOLDER

I certify the information provided is true and correct. I understand that if I provide false information, I could be denied continued medical emergency gas or electric utility service from _____.
Name of Utility Company

I, _____, hereby certify that I am the person responsible for the charges for gas
PRINTED NAME OF PRIMARY ACCOUNT HOLDER

or electric utility service at _____ and that a seriously or chronically ill person
SERVICE ADDRESS
(as defined by Rule 17.5.410.7 NMAC) resides there.

I further certify that I will immediately notify _____ or arrange to have such notification provided, if
Name Of Utility Company
there is a change in the status of the seriously or chronically ill person residing at the Service Address, including relocation or a change in the physical condition of such person which renders continued medical emergency gas or electric utility service unnecessary.

_____ _____
PRIMARY ACCOUNT HOLDER SIGNATURE DATE

DOCTOR'S USE ONLY --

I, _____, certify that: I am (1) a licensed physician or physician's assistant licensed or
PRINTED NAME OF MEDICAL PROFESSIONAL
accepted by the New Mexico Medical Board and practicing under the New Mexico Medical Practice Act, (2) an osteopathic physician or osteopathic physician's assistant practicing under the New Mexico Osteopathic Physician's Practice Act or (3) a certified nurse practitioner licensed by the New Mexico Board of Nursing and practicing under the New Mexico Nursing Practice Act; I hold license number/NPI Number_____; and that on _____
DATE
I examined _____ who I am informed resides at
NAME OF PATIENT
_____.
SERVICE ADDRESS

I certify that the said person has the following condition in which loss of ____gas or ____electric (please indicate type of service by checking) utility service would give rise to substantial risk of death or gravely impair health:

_____
DESCRIBE CONDITION AND REASONS FOR CONTINUED GAS OR 'ELECTRIC UTILITY SERVICE (IF APPLICABLE, LIST MEDICALLY NECESSARY EQUIPMENT)

and that this condition qualifies as a serious or chronic illness pursuant to Rule 17.410.7 NMAC.

DEFINITION OF SERIOUS OR CHRONICALLY ILL PER RULE 17.5.410.7 NMAC: AN ILLNESS OR INJURY THAT RESULTS IN A MEDICAL PROFESSIONAL'S DETERMINATION THAT THE LOSS OF GAS OR ELECTRIC UTILITY SERVICE WOULD GIVE RISE TO A SUBSTANTIAL RISK OF DEATH OR GRAVELY IMPAIR HEALTH.

_____ _____
SIGNATURE OF MEDICAL PROFESSIONAL DATE

_____
OFFICE ADDRESS OF MEDICAL PROFESSIONAL

_____
TELEPHONE NUMBER, AND FAX NUMBER OF MEDICAL PROFESSIONAL

ONLY for patients meeting the requirements for extended medical certification, also complete the additional certification below if it applies to this patient:

DOCTOR'S USE ONLY - EXTENDED MEDICAL CERTIFICATION (VALID FOR 1 YEAR)

I _____certify that the above mentioned patient's medical condition
PRINTED NAME OF MEDICAL PROFESSIONAL

_____is permanent and will not improve within 12 months from _____ (today's date.)
DESCRIPTION OF APPROVED CONDITION

SEE OTHER SIDE FOR FINANCIAL CERTIFICATION