Holston Electric Cooperative

1200 West Main Street
P.O. Box 190
Rogersville, TN 37857-0190

Main Office: (423) 272-8821
Fax: (423) 272-8447

LIFE SUPPORT CLASSIFICATION MEMBER INFORMATION

Holston Electric Cooperative maintains a special classification for our customer, who either themselves or a person living in the customer's home, has a life threatening medical condition which requires special equipment, as specified by the American Medical Association, to provide treatment that, based on reasonable medical judgment, sustains the life of a patient and without which the patient will die. This classification, termed *LIFE SUPPORT CLASSIFICATION*, is for the convenience of the member by placing them on a priority service list. This list is used by cooperative personnel as a means of identifying those customers who require priority in restoring electricity in the event of emergency power interruptions. **Such classification does not guarantee continuous or uninterrupted electric service or in any way increase the responsibility or liability of the Cooperative to the member or patient, but is only an attempt to establish a method to identify those who have a priority need in the event of an emergency. Those under this special classification should, however, make plans for alternate sources of power or alternative lodging during a power outage**.

REQUEST FOR LIFE SUPPORT CLASSIFICATION

1. Complete and sign this Request for Life Support Classification in the form provided by the Cooperative.
2. Submit a completed and signed Request for Equipment Information in the form provided by the Cooperative.
3. Submit a completed and signed Physician's Statement of need in the form provided by the Cooperative.

QUALIFYING LIFE SUPPORT EQUIPMENT

- Kidney dialysis machine
- Apnea monitor for infants (24 months and under)
- Oxygen concentrator
- Respirator
- Ventilator
- Pressure breathing therapy
- Infusion feeding pump
- Peritoneal dialysis machine

**Note: Only certain types/models qualify. Nebulizers and adult apnea monitors do not qualify.*
The Cooperative reserves the right to change the content of the forms in its sole discretion.

After all documents have been received, those who do not meet the American Medical Association's definition of requiring artificial life support will be notified of ineligibility in writing at the address provided in the form. All qualified accounts will be placed on the priority list.

PERIOD OF ELIBILITY The Life Support Classification shall last for one year or until the need for such classification ends, whichever occurs first. It shall be the responsibility of the customer and patient to renew the request for such classification each year without notification from the Cooperative and to notify the Cooperative if the need for such classification ends. Each renewal shall require the same documentation as the original request.

TERMINATION FOR NON-PAYMENT In the event the electric power bill is not paid in the manner provided by Cooperative policies, Holston Electric Cooperative reserves the right to terminate electric utility service. Your classification for this service does not carry with it any special privileges not otherwise available to other members of the Cooperative and timely payment of utility bill will be a requirement for continued service.

Reasonable arrangements to pay late bills can be made in cases of severe hardship as determined by policy. These arrangements must be in writing and signed by the customer and approved by the authorized representative of the Cooperative. Any arrangement must be paid in addition to the current bill.

LIMITS OF LIABILITY The Cooperative assumes no liability, express or implied, in the event of power interruption or termination of electric service for non-payment of a power bill, nor is the Cooperative liable for conditions beyond its control when attempting to restore electric service in emergency or planned interruptions. By signing this agreement, the patient and/or the customer clear the Cooperative of any liability and specifically release, indemnify and hold harmless the Cooperative from any and all liability arising out of any interruption of electric service or the provisions of this policy.

Attention: Please maintain this page for your records.

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MEMBER REQUEST FOR LIFE SUPPORT CLASSIFICATION

Persons having a need to be considered for *LIFE SUPPORT CLASSIFICATION* must complete the Member portion in entirety and return along with the Request for Equipment Information and Physician's Statement within 30 days.

Date _____ Member name on electric bill _____

Member social security number _____ Street address _____

Relation of patient to member _____ City, State Zip code _____

Age of patient _____ Patient name _____

Length of time of medical condition _____ Patient social security number _____

Description of medical illness _____

_____

_____

Hours per day equipment must be used by the patient? _____

Do you have backup power in place for the medical equipment? ☐ Yes ☐ No

If yes, select type of backup power: ☐ Generator ☐ Backup Oxygen ☐ Cylinder ☐ Battery ☐ Other _____

If yes, how many hours will backup last? _____

Can equipment be operated in a satisfactory manner with backup power, such as a portable generator? ☐ Yes ☐ No

Telephone no. of member: _____

Emergency contact name and telephone number: _____

I agree to the conditions stated and understand classification as a life support customer does not relieve me of my obligation to pay my electric bill by the due date stated on the bill. I further agree and understand the Cooperative assumes no liability, express of implied, in the event of a power interruption or termination of electric service for non-payment, nor is the Cooperative liable for conditions beyond its control when attempting to restore electric service in emergency or planned interruptions. It is the responsibility of members under the Life Support Classification to make alternate arrangements for sufficient backup power to support critical equipment and have preparations in place to stay at a different location during extended power outages, and I agree to exculpate the Cooperative of any liability and specifically release, discharge, indemnify, and hold harmless the Cooperative from any and all liability arising out of any interruption of electric service or the provisions of this policy.

I specifically authorize any physicians, medical support personnel, medical equipment providers to release any information concerning the patient necessary for Cooperative to make a decision concerning this request to Holston Electric Cooperative.

_____ _____

Signature of Patient/Legal Guardian Signature of Member

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Name of medical equipment supplier _____

Street address _____ City, State Zip code _____

Telephone number _____

Patient name _____

How long have you been providing medical equipment to the patient? _____

Type of medical equipment provided for the patient:

☐ Kidney dialysis machine ☐ Respirator ☐ Infusion feeding pump
☐ Infant apnea monitor (24 months & under) ☐ Ventilator ☐ Peritoneal dialysis machine
☐ Oxygen concentrator ☐ Pressure breathing therapy ☐ Other _____

Does equipment require electricity? ☐ Yes ☐ No

Can equipment be operated in a satisfactory manner with backup power, such as a portable generator? ☐ Yes ☐ No

How many hours will backup last? _____

_____ Date _____
Signature of Medical Equipment Supplier Representative

I, the patient or legal guardian, authorize the medical equipment supplier and medical support personnel to complete this request form and provide any medical or equipment information necessary to determine my status for *LIFE SUPPORT CLASSIFICATION* to Holston Electric Cooperative, Inc.

_____ Date _____
Signature of Patient/Legal Guardian

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REQUEST FOR PHYSICIAN'S STATEMENT

Holston Electric Cooperative maintains a special classification for our customer, who either themselves or a person living in the customer's home, has a life threatening medical condition which requires special equipment, as specified by the American Medical Association, to provide treatment that, based on reasonable medical judgment, sustains the life of a patient and without which the patient will die. This classification, termed *LIFE SUPPORT CLASSIFICATION*, is for the convenience of the member by placing them on a priority service list. This list is used by cooperative personnel as a means of identifying those customers who require priority in restoring electricity in the event of emergency power interruptions. In order to assist our staff in determining the need for this classification, we request the following information be provided by you:

Name of physician _____

Street address _____ City, State Zip code _____

Patient name _____How long have you provided medical assistance to patient? _____

Description of medical illness _____

_____

_____

Can patient be moved to medical facility or other location in the event of a power outage? ☐ Yes ☐ No

Does medical condition require special life support equipment? ☐ Yes ☐ No Is equipment Life Sustaining? ☐ Yes ☐ No

Type of medical equipment required for the patient:

☐ Kidney dialysis machine	☐ Ventilator	☐ Peritoneal dialysis machine
☐ Oxygen concentrator	☐ Pressure breathing therapy	☐ Infant Apnea monitor (24 months & under)
☐ Respirator	☐ Infusion feeding pump	☐ Other _____

Hours per day equipment must be used by the patient?_____

Can equipment be operated in a satisfactory manner with backup power, such as a portable generator? ☐ Yes ☐ No

The patient's life would be threatened if he/she was unable to use the prescribed equipment due to a power interruption for:

☐ Less than 8 hours ☐ 8-12 hours ☐ 12-24 hours ☐ 24 hours ☐ Not life threatening

_____ _____

Signature of Physician Date

I, the patient or legal guardian, authorize the medical equipment supplier and medical support personnel to complete this request form and provide any medical or equipment information necessary to determine my status for *LIFE SUPPORT CLASSIFICATION* to Holston Electric Cooperative, Inc.

_____ _____

Signature of Patient/Legal Guardian Date