TOWN OF LIBERTY UTILITY MEDICAL CERTIFICATION FORM

Instructions to Customer: Section 1 and Section 2 must be completed and signed by the utility account holder. Section 3 and Section 4 must be completed and signed by a licensed medical professional in the state of Indiana or Ohio (MD, DO, PA or NP).

The completed form must be returned to the Town of Liberty Administration Building at least forty-eight (48) hours prior to any scheduled disconnection.

SECTION 1: CUSTOMER AND ACCOUNT INFORMATION (To be completed by Customer)

a. Utility Account Number:_____

b. Account Holder Name:_____

c. Service Address:_____

d. Primary Phone Number (_____) _____

e. Patient's Name (if different from account holder):_____

f. Patient's Relationship to Account Holder:_____

SECTION 2: CUSTOMER PRIVACY RELEASE AND ACKNOWLEDGEMENT (To be completed by Customer)

I hereby authorize the medical professional signing below to confirm the authenticity of this document and release the specific medical information requested on this form to the Town of Liberty for the sole purpose of verifying my eligibility for a temporary medical utility extension.

I acknowledge that this extension is temporary (maximum 30 days), does not erase my debt, and requires me to enter into a Deferred Payment Agreement with the Town within seven (7) calendar days.

Account Holder Signature:_____Date:_____

SECTION 3: MEDICAL PROFESSIONAL INFORMATION (To be completed by Medical Professional)

a. Medical Professional Name_____

b. Title Credentials (e.g. MD, DO, NP, PA):_____

c. Indiana/Ohio State License Number:_____

d. Medical Facility/Clinic Name:_____

e. Clinic Address:_____

f. Office Phone Number: (_____) _____

SECTION 4: MEDICAL NECESSITY DETERMINATION (To be completed by Medical Professional)

1. Does the patient named in Section 1 reside full-time at the service address listed?
   [ ] YES [ ] NO

2. Will termination of utility service (water/wastewater) create an immediate, life-threatening emergency or cause severe medical jeopardy to this patient?
   [ ] YES [ ] NO

3. Does the patient rely on life-support equipment at this residence that requires utility service to operate (e.g., dialysis machine, ventilator, oxygen concentrator)?
   [ ] YES [ ] NO *If Yes, please specify the equipment:*_____

4. What is the expected duration of this acute medical crisis? (*Note: Town policy limits a single extension to a maximum of 30 days).*
   [ ] 1-15 Days [ ] 16-30 Days [ ] Chronic/Long-Term (30+Days)

By signing below, I certify that I am a licensed healthcare provider in the State of Indiana or the State of Ohio. The patient listed above is under my direct medical care, and the medical information provided on this form is true to the best of my professional knowledge.

Medical Professional Signature_____ Date:_____

THE TOWN OF LIBERTY RESERVES THE RIGHT TO CONTACT MEDICAL PROVIDER TO CONFIRM THE INFORMATION COMPLETED IN SECTIONS 3 AND 4.

TOWN OFFICE USE ONLY---DO NOT WRITE BELOW THIS LINE

a. Date Form Received:_____ Received By (Initials)_____

b. Extension Status: [ ] APPROVED [ ] DENIED

c. If Denied, Reason_____

d. New Extension Expiration Date: _____ (*Max 30 days from original shutoff date)*

e. Deadline for Customer to Sign DPA:_____ (*14 calendar days from approval)*

f. Date Deferred Payment Agreement (DPA) Executed_____