GUARDIAN

1. CUSTOMER INFORMATION

GWP Account Name:	Patient's Name:
Address:	Email Address:
GWP Account Number:	
Daytime Contact Name:	Phone:

2. PROGRAM GUIDELINES

Guardian provides monthly bill discounts for customers or household members with doctor prescribed electrically powered medical equipment and space conditioning needs. Discounts are not authorized for devices used for therapeutic purposes, such as whirlpool pumps, heating pads, vaporizers, humidifiers, pool/tank heaters, saunas, hot tubs, medical devices used outside the home, and non-electric powered medical devices. Equipment not listed below may be approved on a case by case basis. Please allow 30-60 days to process your application.

3. INCOME STATUS

Your answer to the following question does not affect your eligibility in the discount program.

Are you Low-Income? ☐ YES **(Go to section #4)** ☐ NO **(Go to section #6)**

4. PUBLIC ASSISTANCE PROGRAMS (For low-income applicants only)

If you, or someone in your household, receives benefits from any of the programs listed below, please check the box and provide a **current** copy of your **Verification of Benefit Letter or other proof** of enrollment for programs checked.
If you checked one of the boxes below, **Skip section #5**

☐ Glendale Care /Senior Care Program
☐ Section 8/HUD
☐ SSI (Supplemental Security Income)
☐ Medi-Cal/Medicaid
☐ CalFresh (Food Stamps)
☐ CARE Program (So Cal Gas)
☐ California Lifeline (Telephone)
☐ Medi-Cal for Families
☐ WIC
☐ LIHEAP
☐ National School Lunch Program(NSLP)
☐ CalWORKs (TANF)

5. SOURCE OF INCOME (For low-income applicants only)

Please check the appropriate box for all sources of income for all persons in your household and **provide copies of current documents** for all sources checked below. If you checked section #4 above, skip this section.

☐ SSA, SSP, SSDI
☐ Pensions
☐ Family Support
☐ Spousal or Child Support
☐ Wages or Salaries
☐ Unemployment Benefits
☐ Workers Compensation
☐ Scholarships, Grants
☐ Interest, Dividends, Annuities
☐ Rental or Royalty Income
☐ Profit and Loss Statement
☐ Cash or other income

The total number of residents living in my home, including myself is: _____

6. CONDITIONS FOR PARTICIPATING

- Must be a GWP electric customer or a household member with a doctor prescribed special electric-powered medical equipment or with space conditioning needs. Only one discount is allowed per household.
- Participant must reapply each time they move and recertify eligibility annually or when requested.
- Participant must notify GWP within thirty (30) days if they become ineligible for the program.
- Must allow GWP access to the home to determine the manufacturer and ampere if requested by GWP.
- Must acknowledge that GWP does not guarantee continuous power, and declare the number of hours of emergency backup arranged for by the customer.
- Eligible medical equipment includes:

Aerosol Tent	Extremity Pump	Infusion Pump	Nerve Stimulator	Reverse Osmosis
Apnea Monitor	Feeding Pump	Iron Lung	Nebulizer	Respirator
Blood Pump	Hemodialysis	Kidney Dialysis	Oxygen Concentrator	Suction Machine
CPAP/Bi PAP	Heparin Pump	Motorized Wheelchair	Pressure Pump	Ventilator

- Customers with special medically prescribed electric heat or air conditioning needs may also be eligible for the program on a case by case basis. Eligible conditions include households with paraplegic, quadriplegic, or hemiplegic members and/or households with members suffering from scleroderma and/or multiple sclerosis.
- Must agree to pay all City of Glendale service bills when due, and make reasonable attempts to pay any past due amounts owed. Guardian discount will be removed if account is delinquent.

7. MEDICAL EQUIPMENT INFORMATION

Information regarding the amperes, manufacturer, and model number can be found on the metal faceplate attached to the outside surface of the device.

1. Medical Equipment Name	**Brand Name**	**Manufacturer/Model Number**	
Equipment Provider Telephone Number		Amperes	Hours Used Per Day
2. Medical Equipment Name	**Brand Name**	**Manufacturer/Model Number**	
Equipment Provider Telephone Number		Amperes	Hours Used Per Day
3. Medical Equipment Name	**Brand Name**	**Manufacturer/Model Number**	
Equipment Provider Telephone Number		Amperes	Hours Used Per Day
4. Medical Equipment Name	**Brand Name**	**Manufacturer/Model Number**	
Equipment Provider Telephone Number		Amperes	Hours Used Per Day
5. Medical Equipment Name	**Brand Name**	**Manufacturer/Model Number**	
Equipment Provider Telephone Number		Amperes	Hours Used Per Day

8. CUSTOMER AUTHORIZATION

I certify under penalty of perjury that the information provided herein is true and correct. I understand that providing misinformation can disqualify me for this and other PBC programs. I understand that **GWP CANNOT GUARANTEE CONTINUOUS ELECTRIC SERVICE. IT IS MY RESPONSIBILITY TO MAKE BACKUP ARRANGEMENTS IN CASE OF A POWER OUTAGE**. I further agree to give GWP access to my home to determine the manufacturer and ampere rating of my equipment if none is supplied, and for program auditing purposes.

IN CASE OF A POWER OUTAGE, I HAVE _____ HOURS OF EMERGENCY ELECTRICAL COVERAGE.

_____ _____

GWP CUSTOMER SIGNATURE **Date**

Mail application and copies of supporting documents to:

Glendale Water & Power
Conservation and Utility/Business Modernization Division
141 N. Glendale Ave., Level 2
Glendale CA 91206-4496
(818)548-3368
www.GlendaleWaterAndPower.com

GWP Account #: _____

MEDICAL DOCTOR FORM

Guardian Program

This form is to be completed by the prescribing medical doctor of the person living in the household with the special medical equipment or space conditioning need. Applicant must return the completed Guardian recertification application along with this Medical Doctor Form to Glendale Water & Power by.

Glendale Water & Power's Guardian program provides monthly bill discounts for customers or household members with doctor prescribed electrically powered medical equipment and space conditioning needs. Discounts are not authorized for devices used for therapeutic purposes, such as whirlpool pumps, heating pads, vaporizers, humidifiers, pool/tank heaters, saunas, hot tubs, medical devices used outside the home, and non-electric powered medical devices. Customers with special medically prescribed electric heat or air conditioning needs may also be eligible for the program on a case by case basis. Eligible conditions include households with paraplegic, quadriplegic, or hemiplegic members and/or households with members suffering from scleroderma and/or multiple sclerosis.

Patient's name: _____ Date of Birth: _____

Patient's service address: _____

Patient suffers from _____ Kaiser MRN Number: _____
And requires the following medical equipment:

Type of Equipment Prescribed	Hours Per Day	Months/ Lifetime	Is equipment considered essential for LIFE SUPPORT?
			YES / NO
			YES / NO
			YES / NO
			YES / NO

Does the patient require Special Space Heating or Cooling? **YES / NO**

- **If Yes**, Special Space Heating or Cooling is required for: ☐ **Lifetime or _____ Months**
- Is Special Space Heating or Cooling essential for **LIFE SUPPORT?** **YES / NO**

Patient has Scleroderma or Multiple Sclerosis? **YES / NO**

Patient is a Paraplegic, Quadriplegic, or Hemiplegic? **YES / NO**

_____ _____ _____
Doctor's Name **Phone Number** **Fax Number**

I hereby certify that the above information is true and accurate as of the date signed.

_____ _____ _____
Doctor's Signature **CA Medical License Number** **Date**

Rev. July 01, 2022