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Metropolitan Kansas City: (816) 471-5275  
Toll-free: 1-888-471-5275

## MEDICAL CUSTOMER APPLICATION

**ACCEPTANCE INTO THE MEDICAL CUSTOMER PROGRAM DOES NOT GUARANTEE CONTINUOUS ELECTRICAL SERVICE. CUSTOMERS WHOSE SERVICE IS CRITICAL FOR LIFE SUPPORT SHOULD MAKE PRIOR EMERGENCY ARRANGEMENTS TO ACCOMMODATE THE MEDICAL PATIENT DURING POWER INTERRUPTIONS. IF ACCEPTED, A RENEWAL APPLICATION MUST BE SUBMITTED ANNUALLY.**

### TO BE FILLED IN BY CUSTOMER (Please print clearly)

Customer Name _____		Account Number _____			
Street Address _____	City & State _____	Zip Code _____	Home Phone _____	Work Phone _____	Cell Phone _____
Name of Secondary Contact—Required _____	Home Phone _____	Work Phone _____	Cell Phone _____		
Patient's Name _____	Birth Date _____				

**For your protection the law requires you to be advised:** It is a criminal act to make a false or fraudulent claim, or assistance in the preparation or presentation of a false or fraudulent claim. Violators of the provision may be subject to criminal persecution.  
**Authorization:** I hereby authorize release of any medical information, including direct consultation with any physician, that is pertinent to my qualifying as a Medical Customer with KCP&L. By signing below, I acknowledge the accuracy and truth of the information provided.

Signature of Patient or Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_

### TO BE FILLED IN BY PHYSICIAN

PLEASE RESPOND TO THE FOLLOWING ISSUES:

Nature of Ailment \_\_\_\_\_ Is the patient homebound? YES \_\_\_\_\_ NO \_\_\_\_\_

Is electrically powered medical equipment required to sustain life? YES \_\_\_\_\_ NO \_\_\_\_\_ If so, what type of equipment? \_\_\_\_\_

Will the absence of electricity result in an immediate life-threatening situation? YES \_\_\_\_\_ NO \_\_\_\_\_ If so, how? \_\_\_\_\_

Is the medical equipment **capable** of being operated by battery-supplied electricity? YES \_\_\_\_\_ NO \_\_\_\_\_

How often is the medical equipment used? \_\_\_\_\_

Have you advised your patient of the action to take in case his or her medical equipment fails to operate for any reason? YES \_\_\_\_\_ NO \_\_\_\_\_

If so, what is the plan of action? \_\_\_\_\_

Is the patient's condition temporary? Yes \_\_\_\_\_ NO \_\_\_\_\_ If so, when will the condition warrant removal from medical customer list? \_\_\_\_\_

Additional Comments: \_\_\_\_\_

Physician's Name (Please Print) _____	Office Address _____	Phone _____
Physician's Signature _____	City, State, Zip Code _____	Date _____

### FOR KCPL USE ONLY

APPROVED:  REJECTED  BY: \_\_\_\_\_ DATE: \_\_\_\_\_