APPENDIX 1: SPECIAL ASSISTANCE ALLOWANCE APPLICATION

Used for Special Assistance Allowance Enrolment and Re-Certification

PART 1 **TO BE COMPLETED BY CUSTOMER** ***(please print)***

TAU Customer Connection No: _____

Customer Name *(as it appears on your bill):* _____

Special Assistance Allowance Resident's Name *(if different):* _____

Customer Mailing Address: _____

Home Phone: _____ Work Phone: _____

I understand that:

1. If the Doctor certifies the resident's medical condition is permanent, Te Aponga Uira (TAU) will require completion of a form self-certifying continued resident's eligibility for Special Assistance Allowance every two years.
2. If the Doctor certifies the resident's medical condition is not permanent, TAU will require completion of a form self-certifying continued resident's eligibility for Special Assistance Allowance each year and completion of a new application with a doctor's certification every two years.
3. TAU cannot guarantee uninterrupted electric service and I am responsible for making alternate arrangements in the event of an electric outage.

I certify that the above information is correct. I also certify that the Special Assistance Allowance resident lives full-time at this connection number, and requires or continues to require the Special Assistance Allowance. I agree to allow TAU to verify this information. **I also agree to promptly notify TAU if the qualified resident moves or Special Assistance Allowance is no longer needed by the resident.**

Customer Signature: _____ Date: _____

PART 2: **TO BE COMPLETED BY A REGISTERED MEDICAL DOCTOR (M.D.)**

I certify that the medical condition and needs of my patient (please print):

_____

Last Name *First Name*

Requires use of a life-support device*

The following life-support device(s) is/are used in the above named patient's home:

Device: _____

Device: _____

Device: _____

* A qualifying life-support device is any medical device used to sustain life.

I certify that the life support device(s) will be required for approximately:

(complete one) ☐ **No. of Years** _____ *or* ☐ **Permanently**

Doctor's name: _____

Phone No: _____

Office address: _____

Signature of Doctor: _____

Date: _____