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*):	
Qualifying Person's Name (*if different from above*):	
Customer Email Address	
Home Phone No.:	
Work Phone No.:	

I understand that:

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

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

Customer Signature:	Date:

PART 2: **TO BE COMPLETED BY A REGISTERED LOCAL MEDICAL DOCTOR (M.D.)**	
I certify that the life-threatening 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 that consumes significant amounts of mains electric power.	
I certify that the life support device(s) will be required for approximately: (Complete one)	
☐ **No. of years_____**	☐ **Permanently**
Doctor's Name:	
Phone No. :	
Official Address:	
Signature of Doctor	
Date:	