



Dear Customer,

Burbank Water and Power offers a special rate for low-income customers who are either **(1) a senior over 62;** **(2) a person with a permanent disability or (3) require the use of life support equipment in their home.** This packet includes instructions and income guidelines for our Lifeline/LifeSupport program. Income eligible customers are exempt from the monthly Customer Service Charge, Utility User's Tax, and receive reduced rates on their electric service as well as refuse and sewer services. Life Support customers who do not meet the income qualifications shall be exempt from the Utility User's Tax.

To apply, please complete the first two pages and have your doctor complete the Statement of Certification **if you are under age 62 or require LifeSupport equipment in your home.** Attach copies of all appropriate statements, letters, or other information for each household member to document household income. All information is kept strictly confidential. At a minimum, supporting documentation shall include the following for each household member:

- Tax return (most recent year filed)
- Two months of recent bank statements
- Any contracts regarding housing assistance received from Burbank Housing Authority

Your combined household income must be at or below the income levels listed below to qualify for this program:

<u>Household Size</u>	<u>Income Level</u>
One Person	\$26,550
Two People	\$30,300
Three People	\$34,100
Four People	\$37,900
Five People	\$40,950
Six People	\$43,950
Seven People	\$47,000
Eight or More People	\$50,050

Failure to send in copies of appropriate documentation of your **combined** household income **WITH** your completed application will delay processing and may disqualify the household from consideration. If you have any questions, please call us at 818-238-3722. Please mail your completed application and copies of combined household income to:

**Burbank Water and Power**  
**Customer Service – Lifeline/LifeSupport Program**  
**P. O. Box 631**  
**Burbank, CA 91503**

**Burbank Water and Power  
APPLICATION FOR LIFELINE/LIFESUPPORT PROGRAM**

LAST NAME ( <b>BWP Account Holder</b> )	FIRST NAME
LAST NAME ( <b>Life Support Applicant - if different</b> )	FIRST NAME
ADDRESS:	ZIP:
HOME PHONE:	ACCOUNT NUMBER:

**List all household members:** (if more space needed, please complete on back)

HOUSEHOLD MEMBER NAME	SOCIAL SECURITY NUMBER	RELATIONSHIP TO APPLICANT	DATE OF BIRTH Month/Day/Year
		<b>SELF</b>	

What is your monthly rent/mortgage payment? \$ \_\_\_\_\_

**List all household income:** (if more space needed, please complete on back)

TYPE OF INCOME RECEIVED	AMOUNT RECEIVED	WEEKLY/MONTHLY
<b>Social Security</b>		
<b>SSI</b>		
<b>Wages</b>		
<b>Pension</b>		
<b>Housing Assistance (section 8 or other)</b>		
<b>Interest Income</b>		
<b>Annuity</b>		
<b>Disability</b>		
<b>Spousal / Child / Family Support</b>		
<b>Welfare / Food Stamps</b>		
<b>AFDC / CAPI</b>		
<b>Other</b>		

**PLEASE READ THE FOLLOWING AGREEMENT, SIGN, DATE AND RETURN WITH YOUR COMPLETED APPLICATION TO ENSURE CONSIDERATION.**

**DISCLOSURE AND AUTHORIZATION TO OBTAIN INFORMATION**

As a customer of Burbank Water and Power (BWP), I hereby claim eligibility and make application for the Lifeline/LifeSupport program. The device described on this form is used in my home and is an essential life support unit powered by energy supplied by BWP. A new application must be completed when there is a change of address, change in the number of members in the household, change in household income, and/or once a year when an update is due.

I hereby grant right of access to my residence during regular business hours to BWP employees for verification of information given on this application. I understand that refusal of access for this purpose as well as refusal to provide all documentation requested will be considered just cause for denial of LifeSupport rate assistance. I agree to notify BWP at the immediate termination of use of the Life Support equipment.

I understand if my account becomes delinquent I will be subject to the collection process up to and including disconnection of services.

I hereby authorize the Burbank Housing Authority to release any information regarding my housing assistance contract that may be requested by BWP.

I authorize BWP to contact my doctor to release pertinent information relating to my medical history, diagnosis, LifeSupport equipment, tolerance time, and any medical information necessary to update my Lifeline/LifeSupport status.

While applying for rate assistance with BWP, I understand that prior to, or at any time after the acceptance of my application, a consumer report and/or an employment credit report may be requested from Infolink Screening Services, Inc. a Kroll Company, or via Kroll directly. Verification and inquiries that may be requested include, but are not limited to: Marital Status, Credit History Activity, Employment, Income and Assets, Residences, Rental Property Income, and Social Security Verification.

I understand that any Consumer Report or Investigative Consumer Report requested would be used strictly for permissible purposes under section 604 (a) (f) (I) due to a legitimate business need for the information in connection with the application for the rate assistance with BWP initiated by you. I understand, to be considered, I must authorize the procurement of such Report(s). A photographic or faxed copy of this form shall be as valid as the original.

**Note:** Burbank Water and Power makes every effort to prevent interruption of service. However, power outages may be caused by unforeseen circumstances and continuous service cannot be guaranteed. It is recommended that customers using LifeSupport equipment acquire back-up systems and make plans appropriate for their circumstances. I understand that it is my responsibility to have battery back-up for the LifeSupport equipment in my home.

**WARNING! TITLE 18, SECTION 1001 OF THE UNITED STATES CODE, STATES THAT A PERSON IS GUILTY OF A FELONY FOR KNOWINGLY AND WILLINGLY MAKING FALSE OR FRAUDULENT STATEMENTS TO ANY DEPARTMENT OR AGENCY OF THE UNITED STATES.**

**BURBANK WATER AND POWER RESERVES THE RIGHT TO BACK BILL AN APPLICANT IF THEY ARE FOUND TO HAVE COMMITTED FRAUD WITH RESPECT TO THE INFORMATION PROVIDED ON THIS APPLICATION.**

**I DO HEREBY SWEAR AND ATTEST THAT ALL INFORMATION ABOVE ABOUT ME OR MY HOUSEHOLD MEMBERS IS TRUE AND CORRECT.**

CUSTOMER NAME \_\_\_\_\_  
(Please Print)

ADDRESS \_\_\_\_\_

SOCIAL SECURITY NUMBER \_\_\_\_\_ DRIVERS' LICENSE NUMBER \_\_\_\_\_ STATE \_\_\_\_\_

OTHER LEGAL NAMES USED \_\_\_\_\_

CUSTOMER SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

APPLICATION PREPARED BY \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
(if other than customer)

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_ PHONE \_\_\_\_\_

I understand that in California, Minnesota, or Oklahoma if a Consumer Report/Investigative Consumer Report (including any Credit Report) was requested, I may order a copy of such report and it will be mailed to me:  
 Yes, please send me a copy of my Report

**Burbank Water and Power**  
**STATEMENT OF CERTIFICATION**

**This page must be completed by your physician licensed to practice medicine in the State of California.**

PLEASE PRINT ALL INFORMATION LEGIBLY

**NOTE: INCOMPLETE OR ILLEGIBLE APPLICATIONS WILL RESULT IN A DELAY IN PROCESSING.**

**Your physician must complete and sign (box below) this section if you are under age 62.**

1. Patient Name \_\_\_\_\_

2. What is the patient's diagnosis? If more than one, list all  
**DO NOT ABBREVIATE. ATTACH SEPARATE SHEET IF NEEDED**

\_\_\_\_\_

3. Is your patient permanently disabled? YES \_\_\_\_\_ NO \_\_\_\_\_

4. Does your patient's diagnosis prevent him/her from being gainfully employed? YES \_\_\_\_\_ NO \_\_\_\_\_

5. **Does your patient require the use of LifeSupport equipment in the home?** YES \_\_\_\_\_ **If no, please skip to #13.**  
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6. List medical equipment required by patient for in-home use \_\_\_\_\_

7. Is the usage constant or intermittent as needed? \_\_\_\_\_

8. To be eligible for the LifeSupport program, the equipment must be used to maintain life. In your opinion, does the equipment described above meet this criterion? YES \_\_\_\_\_ NO \_\_\_\_\_

9. Does the equipment *require* electricity to operate? YES \_\_\_\_\_ NO \_\_\_\_\_

10. How long will the patient be required to use such equipment?  
\_\_\_\_\_ Days \_\_\_\_\_ Weeks \_\_\_\_\_ Months \_\_\_\_\_ Years \_\_\_\_\_ other

11. In case of emergency, what is the longest tolerance time your patient can survive without the use of the equipment without producing death or serious physiological damage?  
(Give maximum time allowed) \_\_\_\_\_ Hours \_\_\_\_\_ Minutes

**LIFE SUPPORT EQUIPMENT INFORMATION**

12. Life Support device(s) currently in use in the home	Manufacturer (do not abbreviate)	Required Hrs. Per Day

13. Does the patient have back-up battery power for their personal needs? YES \_\_\_\_\_ NO \_\_\_\_\_

\*\*\*\*\*  
I hereby certify the above information is true and accurate as of the date signed. (please print legibly or stamp)

15. Doctor's Name		CA License Number	
Address		City	Zip Code
Telephone	Signature of Doctor	Date	