



MEDICAL NECESSITY PROGRAM APPLICATION

Important Information:

- This application must be completed to obtain a Chronic or Critical Care designation with Fayette Electric Cooperative, Inc. (FEC).
- This application will not be processed if incomplete, unreadable, or improperly submitted. All information is required, unless otherwise indicated.
- **Submission of this application does not automatically result in a Chronic or Critical Care designation.**
- Members will be notified when the designation is due for renewal, which will be every 2 years.
- Designation as a Chronic or Critical Care residential member does not relieve a member of the obligation to pay for electric service, and service may be disconnected for failure to pay.
- **Chronic or Critical Care designation does not guarantee continuous electric power. If electricity is a necessity for sustaining life, you must make alternative arrangements for on-site backup capabilities or other options in the event of power loss.**
- It is important that we have the most current phone number and mailing address on record. Members who have registered their FEC account(s) through SmartHub may also receive notifications via the registration email address.

Instructions for Medical Necessity Program Application:

MEMBER: Complete Part 1 of the application and provide to the patient's physician to complete

PHYSICIAN: Complete Part 2 of the application

MEMBER: Return completed and signed application to FEC's office

Office location: 2111 N. Von Minden Road, La Grange, TX 78945

Mail: Mail to Fayette Electric Cooperative, Inc., Attn: Operations Department, PO Box 490, La Grange, TX 78945.

Email: electric@fayette.coop

Fax: 979-968-6752, Attn: Operations Department

MEDICAL NECESSITY PROGRAM APPLICATION - CONTINUED

PART 1. COMPLETED BY THE MEMBER - ALL INFORMATION IS REQUIRED

Member Name on FEC Account: _____

Patient name: _____
(Name of patient living permanently at the service location who requires chronic condition or critical designation. The patient may be the same person as the member.)

FEC Account Number: _____

Generator? _____

Service Location: _____

City: _____ State: _____ Zip: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Member Primary Phone: _____ Alternate Phone (if any): _____

Emergency (Secondary) Contact Information (Your application will be rejected unless you include an Emergency Contact name. Failure to include an Emergency Contact may result in the disconnection of your electric service without notice if FEC is unable to contact you.)

Emergency Contact Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Member Primary Phone: _____ Alternate Phone (if any): _____

MEMBER – I have read and understand FEC’s information on the Medical Necessity Program and certify that the information provided on this application is correct. I understand the information may also be used to determine whether I am eligible for additional notices relating to my electric service. I agree to be contacted by telephone at the phone numbers listed above with respect to the Medical Necessity Program. Fayette Electric Cooperative, Inc. is not liable for delayed or undelivered notifications.

Member Signature: _____

PATIENT/PATIENTS GUARDIAN, PARENT, OR MANAGING CONSERVATOR – I have read and understand the information on the Medical Necessity Program and certify that the information provided in this application about me (or the patient) is correct. I agree to the release of the information on this form concerning my (or the patient’s) medical condition for the purposes stated in this application.

Patient/Guardian/Parent or Managing Conservator Signature: _____

MEDICAL NECESSITY PROGRAM APPLICATION - CONTINUED

PART 2. COMPLETED BY THE PATIENT'S PHYSICIAN - ALL INFORMATION IS REQUIRED

CHRONIC CONDITION:

The patient has a serious medical condition that requires an electric-powered medical device or electric heating or cooling to prevent impairment of a major life function through a significant deterioration or exacerbation of the person's medical condition.

YES

NO

If yes to the above, has the medical condition been diagnosed as a lifelong condition?

OR

CRITICAL CARE CONDITION:

The patient is dependent upon an electric-powered medical device to sustain life.

YES

NO

If yes to the above, has the medical condition been diagnosed as a lifelong condition?

YES

NO

Does the member currently have back up devices? If so, what?

Physician Name (please print): _____

Texas Medical Board License Number: _____

Phone: _____

Physician Signature: _____