

Medical Assistance Program 2023 Application

The Medical Assistance Program provides financial assistance through electric medical rates to residential customers who:

- require the use of medically necessary equipment in their home, and/or
- have medical conditions that require air conditioning during the summer billing months.

Please note:

- This program is available to all qualifying residential electric customers.
- Processing takes 4-6 weeks from the date the application is received.
- Customers are required to apply for this electric medical rate each calendar year.

PHYSICIAN INFORMATION

Patient's full name: _____

Physician's full name: _____ Phone: _____

Office address: _____ City: _____ ZIP code: _____

Physician must complete and sign this section.

Please check one of the following options. For a list of HCPCS codes, visit hcpcs.codes/e-codes.

Medical equipment* (E126/A126)

My patient, residing at the service address on this application, has a medical condition that requires the following medically necessary equipment at the patient's residence: _____

REQUIRED: HCPCS Code (Healthcare Common Procedure Coding System Code): _____

Medically necessary air conditioning (E127/A127)

My patient, residing at the service address on this application, has a severe immune compromising medical condition (multiple sclerosis, quadriplegia, paraplegia, scleroderma or hemiplegia), and air conditioning at such patient's residence is medically necessary.

Medical equipment and air conditioning (E128/A128)

My patient requires medically necessary equipment **and** air conditioning at the service address on this application.

REQUIRED: HCPCS Code (Healthcare Common Procedure Coding System Code): _____

Physician's signature: _____ Date: _____

Colorado medical license number: _____

SUBMITTAL INSTRUCTIONS

Complete all areas of this form:

- Physician/ HCPCS Code information (*completed by physician*)
- Customer information (*reverse side*)
- Affidavit of lawful presence in the United States (*reverse side*)
- Affidavit of income eligibility (*reverse side*)

Return to Fort Collins Utilities.

Mail to: Fort Collins Utilities
Customer Service Division
PO Box 580
Fort Collins, CO 80522-0580

In person: Fort Collins Utilities
Customer Service Division
222 Laporte Ave.
Fort Collins, CO 80521

Find this application and
more information at:
fcgov.com/MAP

Medical Assistance Program

2023 Application



CUSTOMER INFORMATION

Applicant must complete and sign this section. To be completed by Fort Collins Utilities account holder - PLEASE PRINT

Account holder(s) name(s): _____

Account number: _____ - _____ Name of resident at this address requiring assistance: _____

Phone number: _____ Email: _____

Service address*: _____ ZIP code: _____

Number in household: _____ Annual Household Income Range (select one option on next line):

Less than \$34,999 \$35,000-\$44,999 \$45,000-\$54,999 \$55,000-\$64,999 \$65,000-\$76,999 \$77,000+

***If you move and will remain a Fort Collins Utilities Customer, you must notify Utilities to move the rate to the new address.**

Affidavit of income eligibility

to be completed by Utilities account holder

This program is intended to assist customers for whom the costs of running a medical device results in an economic hardship. The income threshold for this program has been set at 60% of the Larimer County Area Median Income (as determined by the Federal Housing Authority). Based on the number of people within this residence and the income ceiling provided in the table at right, I certify that the total household income is **less** than the income ceiling and, thus, this account is eligible for this program. I agree, as a condition of my participation in this program, that **if asked**, I will provide copies of my financial records establishing my household income, including copies of my IRS tax returns.

60% Larimer County Area Median Income

# in Household	Income Limit
1	\$45,120
2	\$51,540
3	\$57,960
4	\$64,380
5	\$69,540
6	\$74,700
7	\$79,860
8+	\$85,020

My signature below certifies all information on this application is true and accurate, that the total household income for this residence is less than the household size adjusted income ceiling in the table above, and the resident named above lives at this address full time and requires medically necessary equipment, used at this address, which requires electricity to operate. I further acknowledge that making a false, fictitious, or fraudulent statement or representation in this sworn affidavit is punishable under the criminal law of Colorado as perjury in the second degree under C.R.S. 18-8-503, and it shall constitute a separate criminal offense each time a public benefit is fraudulently received.

Account holder's signature: _____ **Date:** _____

Application does not guarantee uninterrupted electric service nor prevent disconnection for non-payment.

Customers who are denied medical assistance may submit an appeal to the Utilities executive director based on financial or medical exceptions.

*Medically necessary equipment for this electric medical rate is defined as any durable medical equipment requiring electricity to operate that is required on an ongoing basis by a patient within the residence receiving electric service from Fort Collins Utilities.