Medically Indigent Certification Form

Date Mailed <mail date>

Completion by Customer

Customer Name (please print): _____
Spouse Name -*if spouse being medically certified* (please print): _____
Contract Account Number: _____
Service Address: _____
Mailing Address (if different than Service Address): _____
_____
Telephone Number: Home _____ Work _____
Secondary Contact Name: _____
Relationship: _____Phone Number for Secondary Contact _____

Completion by Certified Representative*

I, (name of certifying representative)_____, representative of (governmental entity or energy assistance program provider)_____, hereby certify that (customer name)_____ has:

- ☐ total income which is at or below 150% of the federal poverty guidelines, and
- ☐ monthly out-of-pocket medical expenses in excess of 20% of the household's gross income

Signature of certifying representative: _____ Date: _____

**The term "certified representative" shall mean a representative of a governmental entity or government funded energy assistance program provider.*

Completion by Patient's Attending Physician*

Attending Physician Name: _____
Attending Physician Address: _____
Attending Physician Phone Number: _____

I hereby certify that (customer or spouse name) _____ is unable to perform three or more activities of daily living due to medical reasons, as defined in 22 TAC §218.2.

Signature of certifying attending physician: _____
Date signed: _____

**The term "physician" shall mean any public health official, including home care providers, medical doctors, doctors of osteopathy, nurse practitioners, registered nurses, state-licensed social workers, state-licensed physical and occupational therapists, and employees of agencies certified to provide home health services pursuant to 42 U.S.C. §1395 et seq.*

Completion by Customer

I hereby certify that the above information is true and correct.

Signature of Customer: _____
Date signed: _____

Completed form must be returned by <Return date – Mail date + 20 days>. Acceptance of this document by Reliant Energy will permit enrollment of the above Contract Account with Reliant Energy without the requested security deposit normally required. Acceptance does not, however, qualify the above Customer for any other programs or services not specifically referenced in this document. Submission of false, misleading or inaccurate information may result in assessment of security deposit from Customer.

Please return completed form in the postage paid envelope (included).

INCOME CALCULATION WORKSHEET

Step 1. *Fill out the Worksheet (to determine your* ***household income*** *accurately, you must include the income of all persons residing in your home from all sources. To determine the amount of income in each category, enter the amount(s) shown on the check or benefit statement.*

Income Source	***Amount per week / month / year*** *(circle one)*
Wages from full or part-time employment as shown on pay stub or W-2 form	1)
Social Security	2)
Retirement Income	3)
Unemployment or Worker's Compensation	4)
Child Support and/or Alimony	5)
All other earnings	6)
Add up boxes 1 through 6	
TOTAL HOUSEHOLD INCOME	

Step 2. *Compare your total household income to the amount shown in the table below for the number of persons in your household and period of time represented. If the result is equal to or less than the amount shown, you meet the income eligibility portion of the requirements.*

Household Size	**Income**		
	Annual	**Month**	**Week**
1	**$13,290**	**$1108**	**$256**
2	**$17,910**	**$1,493**	**$344**
3	**$22,530**	**$1,876**	**$433**
4	**$27,150**	**$2,263**	**$522**
5	**$31,770**	**$2,648**	**$611**
6	**$36,390**	**$3,033**	**$700**
7	**$41,010**	**$3,418**	**$789**
8	**$45,630**	**$3,803**	**$878**