LONG BEACH Utilities
Water · Gas · Sewer

Medical Heating Allowance Program

WHAT IS IT?

Long Beach Utilities is here to help those suffering from serious medical conditions. The Medical Heating Allowance Program allows additional therms of usage at the lower Tier I rate for individuals with qualifying medical conditions.

Those who require life-saving medical equipment that uses natural gas can also qualify for the therm allowance, plus other benefits.

Questions? Call us (562) 570-2068.

ដើម្បីស្នើសុំការជូនដំណឹងនេះ ជាភាសាផ្សេង សូមទាក់ទងទូរសព្ទលេខ
(562) 570-2068

Para solicitar este aviso en otro idioma, llame al
(562) 570-2068

Para hilingin ang abisong ito sa alternatibong wika, pakitawagan ang
(562) 570-2068

HOW TO QUALIFY

Qualifying conditions:

- Paraplegic
- Quadriplegic
- Hemiplegic
- Multiple Sclerosis
- Scleroderma
- Life threatening Illness
- Compromised Immune System
- Emphysema that requires positive pressure breathing apparatus
- Had pneumonia 3 or more times in 12 months as a result of chronic illness
- Paralysis of 2 or more extremities
- Life Support Equipment Required

Note: Life Support Equipment does not include apparatus or appliances used in a hospital or medical clinic, nor does it include therapeutic devices such as pool or tank heaters, saunas, or hot tubs.

HOW TO APPLY

Please fill and sign the application on the next page and email to billing@lbutilities.org or mail to:

Long Beach Utilities Billing
2400 E. Spring St.
Long Beach, CA 90806

Applicants must include signed physician verification letter with application.

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APPLICATION

Utility Account Number: _____

Customer Name: _____

Patient Name (if different): _____

Service Address: _____

_____

Mailing Address: _____

_____

Phone: _____ **Email:** _____

I am a customer of the Long Beach Utilities and I declare that the above-named applicant is a permanent resident at the above service address, qualifying me for an additional monthly therm allowance of gas at the baseline rate.

I understand that eligibility is restricted to the above residential service address, and I agree to notify the City within 10 days of any change in status including, but not limited to:

1. The qualifying person no longer resides at this address
2. The life support equipment is no longer in use, or is removed from the premises
3. The patient no longer suffers from the illness and/or condition

I understand that I must renew the declaration of eligibility within 10 days of written request from the City in order to maintain this additional baseline allowance. I declare under penalty of perjury, the information submitted on this application is true and correct.

Signature: _____ **Date:** _____

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PHYSICIAN VERIFICATION

Must be completed by the patient

Utility Account Number: _____

Patient Name: _____

This patient has a qualifying medical condition from the list below: Y / N

- Paraplegic
- Quadriplegic
- Hemiplegic
- Multiple Sclerosis
- Scleroderma
- Life threatening Illness
- Compromised Immune System
- Emphysema that requires positive pressure breathing apparatus
- Had pneumonia 3 or more times in 12 months as a result of chronic illness
- Paralysis of 2 or more extremities
- Life Support Equipment Required

This patient requires life support equipment powered by natural gas: Y / N

Must be completed by physician

Physician Name: _____

Signature: _____ **Date:** _____

Office Address: _____

Phone: _____ **CA Registration Number:** _____