Colorado

Clear form

Colorado Medical Exemption Program

A special program offered by Xcel Energy and overseen by the Chronic Care Collaborative

Instructions: Please sign and complete the patient form (front page) and have your health care provider sign and complete the Health Care Provider Certification Form (back page). Mail, email or fax the application to us. **Completed applications must be received (not postmarked) by May 1.**

If you are a new enrollee, please complete all the sections on the front and back of this form.

Section I. General information

Name on Xcel Energy account _____

Patient name (if not account holder) _____

Daytime phone _____ Other phone _____

Address _____ Apartment/unit number _____

City _____ State _____ ZIP _____

Please check the box to show the type of service you get from Xcel Energy: ☐ Electricity ☐ Natural gas ☐ Both

Xcel Energy account number _____

If you don't know your account number, please call Xcel Energy's Energy Assistance Program at **866.975.7327**.
We must have your account number to process your application.

Section II. Income information

Please include income from ALL sources and for ALL household members.

What is your current household income? $ _____ per year

How many people live in your household? _____ people

Section III. Signatures

By signing this form:

- I agree to allow Xcel Energy to review my energy usage.
- I agree to allow Xcel Energy to give the Chronic Care Collaborative permission to review data about my account and energy use, including LIHEAP status, to process the application for the Medical Exemption program.
- I agree to allow the Chronic Care Collaborative to share any of the above information with other organizations that provide energy assistance, conservation and other services.

All adults living in your household must sign below.

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

Licensed Health Care Provider Information

The Colorado Medical Exemption Program is offered by Xcel Energy to reduce electricity rates for selected low-income customers who use essential life support equipment or who have medical condition(s) that make it difficult for them to reduce electric usage in the summer (examples include: home dialysis, oxygen and CPAP machines, electric wheelchair, MS, lupus, epilepsy, etc.). You have been asked by your patient to certify that they use essential life support equipment or have a medical diagnosis that would qualify them for this program.

Patient information

Patient name _____

Medical condition/reason for increased energy use by patient _____

_____

_____

Certification and signatures

I certify:

- I have obtained consent from the patient to disclose the medical information necessary to complete this form.
- The patient listed above uses the essential life support indicated and/or has a medical condition(s) that makes it difficult to reduce electricity usage during the summer.
- The patient listed above may have high energy use due to a medical condition.

Provider's full name _____

Office address _____ Suite number _____

City _____ State _____ ZIP _____

Phone _____ State medical license number _____

Provider's signature: _____ Date _____

Please complete, sign and submit your completed application by U.S. mail, attached to email, or by fax.
Applications must be received no later than May 1.

Mail your application to:
Chronic Care Collaborative
Attn: Colorado Medical Exemption Program Office
P.O. Box 461657
Aurora CO 80015-9998

Fax your application to: 303.955.7538.

Email your application to: sabrina.padilla@ccc-co.org

Questions? Please call the Chronic Care Collaborative at 303.993.5056.

On the Web: chroniccarecollaborative.org

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