PR E105-2024

Part 1 (Please print)

SoCalGas Customer Account Number:		
Customer Name (as it appears on your bill):		
Name of Resident with Medical Condition (if different):		
Service Address:		Apt/Space#:
City:	State:	ZIP:
Customer Mailing Address (if different):		Apt/Space#:
City:	State:	ZIP:
Home or Mobile Phone: ( )	Email Address:	

For Customers Billed by Someone Other Than SoCalGas:

Name of Mobile Home or Apartment Complex:		
Complex Address:		
City:	State:	ZIP:
Name of Complex Manager:	Complex Phone: ( )	
Name of Tenant:	Tenant's Phone: ( )	

I Understand That:

- If the medical provider certifies that the resident's medical condition is permanent, SoCalGas will require completion of a form self-certifying continued resident's eligibility for the Medical Baseline Allowance **every four years**.
- If the medical provider certifies that the resident's medical condition is not permanent, SoCalGas will require completion of a new application with a medical provider's certification **every two years**.
- If the resident has a vision disability, the resident may contact SoCalGas to request notification of when re-certification or self-certification forms are mailed.
- SoCalGas cannot guarantee uninterrupted natural gas service, and the resident is responsible for making alternate arrangements in the event of a natural gas outage.

I certify that the above information is correct. I also certify the Medical Baseline Allowance resident lives full-time at this address, and requires or continues to require the medical baseline allowance. I agree to allow SoCalGas to verify this information. **I also agree to promptly notify SoCalGas if the qualified resident moves or the Medical Baseline allowance is no longer needed by the resident.**

X _____ _____

Customer Signature **Date**

NOTE: The standard medical baseline allowance is 0.822 therms of natural gas per day, which is in addition to your daily standard baseline allocation. If this allowance does not meet your medical needs, please contact SoCalGas at 1-800-427-2200 to discuss additional amounts. Hearing impaired customers who are unable to use a conventional telephone can call us at 1-800-252-0259 (available in English and Spanish only).

(Continued)

Part 2 To be completed by a medical provider (Please print)

Medical doctors [M.D.] | Doctors of osteopathy [D.O.] | Nurse practitioners [N.P.] | Physician's assistants [P.A.]

I certify that the medical condition and needs of my patient:

1. Requires Heating

Standard Medical Baseline Allowances are available for heating if patient is paraplegic, quadriplegic, hemiplegic, has multiple sclerosis, scleroderma or has a compromised immune system, life threatening illness, or any other condition for which **additional heating is medically necessary to sustain the person's life or prevent deterioration of the person's medical condition**.

Additional heating is medically necessary: (check one) ☐ **Yes** ☐ **No**

I certify that the additional heating will be required for approximately:

(check one) ☐ **Number of Years** _____ **or** ☐ **Permanently**

2. Requires use of a Life-support Device*

(Check one) ☐ **Yes** ☐ **No**

The following life-support device(s) is(are) used in the patient's home:

Device:	☐ Electricity	☐ Natural gas
Device:	☐ Electricity	☐ Natural gas

*Qualifying life-support equipment is any device which uses mechanical or artificial means to sustain, restore, or supplant a vital function. The device must run on natural gas supplied by SoCalGas. **Devices used for therapy, such as pools and spas, do not qualify.**

Patient's Last Name:	**Patient's First Name:**	
Medical Provider's Name:	**Phone Number: ( )**	
Office Address:		
City:	**State:**	**ZIP:**
State License or Military License Number:		

X _____ _____

Medical Provider's Signature **Date**

Submit Parts 1 & 2 to SoCalGas by email, mail or fax:

Email: MedicalBaselineProgram@socalgas.com

Mail: SoCalGas Medical Baseline Allowance Program
M. L. GT19A1
P.O. Box 513249
Los Angeles, CA 90051-1249

Fax: 213-244-4665