Medical Discount Program Application

Medical Discount Program

1. Account Information

Customer Name (as it appears on your LID bill)		
Service Address		
City		Zip Code
Mailing Address (if different than service address)		
City	State	Zip Code
LID Account Number	Contact Phone Number	

How to Apply

1. **Enter your account information.**
2. **Enter the household and income information.**
3. **Attach a copy of required documentation.**
4. **Sign and date the application (page 1).**
5. **Have the doctor complete the certification (page 2).**
6. **Mail completed application to:**

LATHROP IRRIGATION DISTRICT
P.O. Box 1397
Lathrop, CA 95330

****Incomplete applications will not be processed****

2. Household Information & Income Verification

Total number of persons living in the home (full-time basis): Adults _______ + Minors (under 18) _______ = _______ Total

Proof of income may include award letters, paystubs, etc. **LID will not accept bank statements as proof of gross income.** If you need a copy of your Social Security Award Letter, please contact the local Social Security office by calling 888-748-7698. Documents will not be returned. Household income includes money from all household members (taxable or non-taxable), including but not limited to:

Wages $	____________	TANF (AFDC) $	____________	Spousal support $	____________
Interest income $	____________	Child support $	____________	Rent/royalty income $	____________
Social Security $	____________	Disability payments $	____________	Legal Settlements $	____________
SSI, SSP, SSDI $	____________	Workers compensation $	____________	Scholarships/Grants $	____________
Pensions $	____________	Unemployment benefits	____________	Cash $	____________
				Self-employment income (Schedule C required) $	____________

Other income (explain):____ $

Total Monthly Household Income (Gross):	$	**Monthly household income must be $5,914 or less to qualify. Effective 01/01/2026**

3. Required Documentation

Incomplete applications will not be processed. Please verify the following information is attached:

☐ Proof of Income for all persons in the home ☐ IRS form 4506-T for all adults in the home ☐ Copy of LID Bill

LID cannot guarantee uninterrupted electric service. I am responsible for continuous electric service in the event of power outages or disconnection of service due to non-payment.

The information on this application and required documentation is used to determine and verify my eligibility for assistance. **All information is confidential and is not shared with outside agencies.** It is the customer's responsibility to contact LID if your household income increases above the current limits and/or if the patient no longer requires the medical device(s). LID reserves the right to request further certification at any time while the LID customer is on the program. Misrepresentation of information, failure to disclose all income or failure to provide additional d discount inappropriately received in accordance with the LID Electric Service Rules.

If eligible for discount, I permit the proper change to the rate schedule for the service address listed above and give consent to have my eligibility verified. I declare, under penalty of perjury, that the information on this application is true and correct.

X______________________________________ ____________________

Signature (person whose name appears on LID bill) Date

Please have your doctor complete page 2 (back page) of this application before mailing to LID.

For Physician Use Only

Page 2: To be completed by a Doctor of Medicine or Osteopath, licensed to practice in the State of California

1. Patient Information

Patient Name	Patient Date of Birth	Relationship to Customer

2. Life Support Device *(Check Yes or No for each)*

Devices used for therapy rather than life support do not qualify. Equipment must be plugged in and not battery operated.

☐ Yes ☐ No **IPPB**

☐ Yes ☐ No **Oxygen Concentrator**

☐ Yes ☐ No **Electric Wheelchair**

☐ Yes ☐ No **In-Home Dialysis Cycler**

☐ Yes ☐ No **Other Equipment** *(description)*:____________________

3. Special Heating and Cooling Needs

Medical discount is available for special heating and/or cooling needs if the patient is:

☐ Paraplegic ☐ Quadriplegic ☐ Hemiplegic ☐ Multiple Sclerosis ☐ Scleroderma

Heating or cooling is medically necessary to sustain the person's life or prevent deterioration of the person's medical condition:

☐ Yes ☐ No **Special Cooling Needs** *(description)*:____________________

____

☐ Yes ☐ No **Special Electric Heating Needs** *(description)*:____________________

____

4. Physician Certification *(MD or DO)*

Diagnosis / Medical Condition

I certify that the life support device(s) and/or additional heating or cooling will be required for a minimum of 12 months. Duration of medical condition:

Permanent (Check One) ☐ **Yes** ☐ **No** *Permanent: not expected to change for an indefinite time; not temporary.

Does interruption in power cause a potentially life-threatening medical condition? ☐ Yes ☐ No

Doctor's Name	Phone Number
Office Address	City, State Zip Code
California Medical License Number	Fax Number
Doctor Signature X	Date

LID Use Only

Approved ☐ Yes ☐ No **Recertification Required:** ☐ Annually ☐ Every 2 Years	ES Staff Date ES Supervisor Date	**Reason for Disqualification:** ☐ Equipment does not qualify ☐ Heating/Cooling needs do not qualify ☐ Income does not qualify ☐ Application Incomplete