 DATE:

**Duke Energy**

**APPLICATION FOR SPECIAL MEDICAL NEEDS (SMN) PROGRAM**

**(To be completed by customer)**

**NOTE: Completion of this form DOES NOT guarantee SMN qualification**

# **CUSTOMER NAME: ­­­­­­­­­­­­­­­­** **SS#:**

**ADDRESS**:

**CITY**:      **STATE**: **ZIP:**

**DUKE ENERGY**

**ACCOUNT NUMBER**:       **PHONE #:**

**AMOUNT OF CURRENT BILL**:       **PAST DUE AMT**:

**PATIENT’S NAME**:

**RELATIONSHIP TO CUSTOMER**:

**LAST DATE DATE EXPECTED TO**

**WORKED**:       **return to work**:

DESCRIPTION OF YOUR MEDICAL NEEDS:

## PHYSICIAN’S NAME**:** PHONE **#:**

**\*NOTE: RECIPIENT OF FUNDS MUST BE A CURRENT DUKE ENERGY FLORIDA RESIDENTIAL CUSTOMER WITH A CURRENT CATASTROPHIC MEDICAL CONDITION. THE CUSTOMER SHALL PROVIDE A CURRENT LETTER BY A LICENSED PHYSICIAN, ON THE PHYSICIAN’S LETTERHEAD, OF A CURRENT CATASTROPHIC MEDICAL CONDITION THAT PREVENTS THE CUSTOMER FROM EMPLOYMENT FOR A MINIMUM OF NINETY (90) DAYS AND A MAXIMUM OF ONE-HUNDRED-TWENTY (120) DAYS. CUSTOMER SHALL MEET GUIDELINES ESTABLISHED BY THE PROGRAM.**

**I ACKNOWLEDGE AND UNDERSTAND THE REQUIREMENTS OF THE SPECIAL MEDICAL NEEDS PROGRAM AND GIVE DUKE ENERGY FLORIDA, INC. AND/OR AGENCY PERMISSION TO FOLLOW-UP ON THE MEDICAL INFORMATION I HAVE PROVIDED FROM THE PHYSICIAN CARING FOR THE PATIENT.**

**DUKE ENERGY FLORIDA CUSTOMER SIGNATURE**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- |
| **To be completed by Agency****Customer approved:** **[ ]  Yes** **[ ]  No**Date approved:       Amount Approved:       |

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