

**SOCORRO ELECTRIC COOPERATIVE, INC.
FIFTH REVISED FORM NO. 4
CANCELLING FOURTH REVISED FORM NO. 4**

**DELINQUENT NOTICE – 15 DAY INCLUDING NOTICE OF YOUR RIGHTS
AND RESPONSIBILTIES – FINANCIAL AND MEDICAL CERTIFICATIONS
(ENGLISH AND SPANISH)**

**DELINQUENT NOTICE – 15 DAY INCLUDING NOTICE OF YOUR RIGHTS
AND RESPONSIBILTIES – FINANCIAL AND MEDICAL CERTIFICATIONS
(ENGLISH AND SPANISH)**

(ATTACHED)

NEW MEXICO
SOCIETY OF PROFESSIONAL ACCOUNTANTS
FILED
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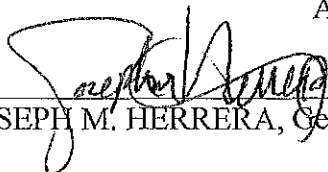
ADVISE NOTICE NO. 67

EFFECTIVE

APR 12 2013

REPLACED BY NMPRC

BY Operation of Law



JOSEPH M. HERRERA, General Manager

MEDICAL CERTIFICATION

NOTE: In order to continue to receive electric service from (Socorro Electric Cooperative, Inc.), a complete Medical and a complete Financial Certification Form must be submitted. This certification is valid for ninety (90) days from the signature date of medical professional.

PATIENT OR LEGAL GUARDIAN

I certify the information provided is true and correct. I understand that if I provide false information, I could be denied continued medical emergency electric utility service from _____.

Socorro Electric Cooperative, Inc.

I, _____, hereby authorize the medical professional signing this certification to

PRINTED NAME OF PATIENT

disclose to _____ the information contained in this Medical Certification Form.

Socorro Electric Cooperative, Inc.

PATIENT OR LEGAL GUARDIAN SIGNATURE

DATE

PRIMARY UTILITY ACCOUNT HOLDER

I certify the information provided is true and correct. I understand that if I provide false information, I could be denied continued medical emergency electric utility service from _____.

Socorro Electric Cooperative, Inc.

I, _____, hereby certify that I am the person responsible for the charges electric

PRINTED NAME OF PRIMARY ACCOUNT HOLDER

utility service at _____ and that a seriously or chronically ill person

SERVICE ADDRESS

(as defined by Rule 17.5.410.7 NMAC) resides there.

I further certify that I will immediately notify _____ or arrange to have such notification provided, if

Socorro Electric Cooperative, Inc.

there is a change in the status of the seriously or chronically ill person residing at the Service Address, including relocation or a change in the physical condition of such person which renders continued medical emergency electric utility service unnecessary.

PRIMARY ACCOUNT HOLDER SIGNATURE

DATE

DOCTOR'S USE ONLY --

I, _____, certify that: I am (1) a licensed physician or physician's assistant licensed or

PRINTED NAME OF MEDICAL PROFESSIONAL

accepted by the New Mexico Medical Board and practicing under the New Mexico Medical Practice Act, (2) an osteopathic physician or osteopathic physician's assistant practicing under the New Mexico Osteopathic Physician's Practice Act or (3) a certified nurse practitioner licensed by the New Mexico Board of Nursing and practicing under the New Mexico Nursing Practice Act; I hold license number/NPI Number _____; and that on _____

DATE

I examined _____ who I am informed resides at _____

NAME OF PATIENT

SERVICE ADDRESS

I certify that the said person has the following condition in which loss of _____ gas or _____ electric (please indicate type of service by checking) utility service would give rise to substantial risk of death or gravely impair health:

DESCRIBE CONDITION AND REASONS FOR CONTINUED GAS OR ELECTRIC UTILITY SERVICE (IF APPLICABLE, LIST MEDICALLY NECESSARY EQUIPMENT)

and that this condition qualifies as a serious or chronic illness pursuant to Rule 17.410.7 NMAC.

DEFINITION OF SERIOUS OR CHRONICALLY ILL PER RULE 17.5.410.7 NMAC: AN ILLNESS OR INJURY THAT RESULTS IN A MEDICAL PROFESSIONAL'S DETERMINATION THAT THE LOSS OF GAS OR ELECTRIC UTILITY SERVICE WOULD GIVE RISE TO A SUBSTANTIAL RISK OF DEATH OR GRAVELY IMPAIR HEALTH.

SIGNATURE OF MEDICAL PROFESSIONAL

DATE

OFFICE ADDRESS OF MEDICAL PROFESSIONAL

TELEPHONE NUMBER, AND FAX NUMBER OF MEDICAL PROFESSIONAL

ONLY for patients meeting the requirements for extended medical certification, also complete the additional certification below if it applies to this patient:

DOCTOR'S USE ONLY - EXTENDED MEDICAL CERTIFICATION (VALID FOR 1 YEAR)

I _____ certify that the above mentioned patient's medical condition

PRINTED NAME OF MEDICAL PROFESSIONAL

_____ is permanent and will not improve within 12 months from _____ (today's date.)

DESCRIPTION OF APPROVED CONDITION

SEE OTHER SIDE FOR FINANCIAL CERTIFICATION

FINANCIAL CERTIFICATION (VALID FOR 90 DAYS ONLY)

BY SIGNING BELOW, I, THE ACCOUNT HOLDER, ACKNOWLEDGE THAT THIS CERTIFICATE DOES NOT RELIEVE ME OF MY RESPONSIBILITY TO PAY MY CURRENT AND PAST BILLS WITH (SOCORRO ELECTRIC COOPERATIVE INC.).

- For Administering Authority (Human Services Department (HSD) or Tribal Authority) certification: complete Sections I and II.

OR

- For self certification: complete Section III and attach a copy of the primary account holder's current Medicaid eligibility.

(Even when Extended Medical Certification is authorized, Financial Recertification is required every 90 days for the Account Holder.)

SECTION I : AUTHORIZATION TO RELEASE INFORMATION - PRIMARY UTILITY ACCOUNT HOLDER

I, _____, authorize Administering Authority to release to (Socorro Electric Cooperative, Inc.)
PRINTED NAME OF PRIMARY ACCOUNT HOLDER
 Information from my file as deemed necessary for the purpose of qualifying for the Medical Certification program.

I certify the information provided is true and correct. I understand that if I provide false information, I can be denied continued medical emergency gas or electric utility service.

PRIMARY ACCOUNT HOLDER'S SIGNATURE	UTILITY ACCOUNT NUMBER	PRIMARY ACCOUNT HOLDER'S SOCIAL SECURITY NUMBER		
PRIMARY ACCOUNT HOLDER'S TELEPHONE NUMBER	SERVICE ADDRESS	CITY	STATE	ZIP CODE

SECTION II - ADMINISTERING AUTHORITY (HSD OR TRIBAL) USE ONLY

I, _____, an authorized representative of _____ hereby certify that
NAME OF AGENCY REPRESENTATIVE **ADMINISTERING AUTHORITY**
 _____, the primary account holder named in Section I currently meets the income
Guide lines as defined by the Administering Authority (such as Low Income Home Energy Assistance Program (LIHEAP) assistance).

AGENCY REPRESENTATIVE SIGNATURE	CONTACT NUMBER AND FAX NUMBER	DATE
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- OR -

SECTION III —SELF CERTIFICATION - PRIMARY ACCOUNT HOLDER ATTACH COPY OF CURRENT NEW MEXICO MEDICAID ELIGIBILITY FOR PRIMARY ACCOUNT HOLDER

I, _____ hereby certify that I am the person responsible for the charges for electric
PRINTED NAME OF PRIMARY ACCOUNT HOLDER
 utility service at _____ and that a seriously or chronically ill person (as defined by Rule 17.5.410.7
SERVICE ADDRESS
 NMAC) _____ resides there.
PATIENT'S NAME

I certify the information provided is true and correct. I understand that if I provide false information, I could be denied continued medical emergency gas or electric utility service.

PRIMARY ACCOUNT HOLDER SIGNATURE	DATE	PRIMARY ACCOUNT HOLDER'S SOCIAL SECURITY NO.	
SERVICE ADDRESS	CITY	STATE	ZIP CODE

It is in the account holder's best interest to make regular payments toward current and past due balances; the account holder is encouraged to contact (Socorro Electric Cooperative Inc.) to make payment arrangements.

SEE OTHER SIDE FOR MEDICAL CERTIFICATION