rhythm

Medically Indigent Certification Form

Customer Name:
Phone Number:
Email address:
ESIID:
Service Address:

Mailing Address:

Contact Name:
Contact Relationship:
Contact Phone Number:

Section to be completed by Certified Representative:
"Certified representative" shall mean a representative of a governmental entity of government-funded energy assistance program provider.
I hereby certify that this customer has:

1. Total income which is at or below 150% of the federal poverty guidelines; and,
2. Monthly out-of-pocket expenses in excess of 20% of the household's gross income.

Signature:
Printed Name:
Entity Represented:
Address:
Date:

Section to be completed by Customer's Attending Physician:
I hereby certify that the customer is unable to perform three or more activities of daily living due to medical reasons including bathing, dressing, grooming, routine hair and skin care, meal preparation, feeding, exercising, toileting, transfer/ambulation, positioning, and range of motion.

Signature:
Printed Name:
Medical Practice Name:
Address:
Phone Number:
Date:

Section to be completed by Customer:
I hereby certify that the above information is true and correct.

Signature:
Printed Name:
Date:

Please return completed form as soon as possible to avoid delay in your service request. Acceptance of this document by Rhythm will permit enrollment of the above premise with Rhythm without the requested security deposit normally required. Acceptance does not, however, qualify the above Customer for any other programs or services not specifically referenced in this document. Submission of false, misleading, or inaccurate information may result in assessment of security deposit. Please send completed forms by email to support@gotrhythm.com.

We look forward to serving you,
Rhythm
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