CRITICAL NEEDS PROGRAM APPLICATION

Customer Name: _____
Last First

Service Address: _____

Telephone Number: _____

Cell Phone Number: _____

Type of Equipment Used: _____

_____

Back-up Equipment (Battery): _____

What is the back-up time available? _____

Do you wish to be contacted if an outage occurs during sleeping hours (10pm - 6am)? Yes: ☐ No: ☐

If we do not receive an answer when trying to call you, do you want us to try to call someone else? Yes: ☐ Yes: ☐

_____
If yes, name and telephone number.

I UNDERSTAND that it is solely my responsibility to develop and implement an emergency Preparedness Plan for back-up power including phone numbers for assistance, an alternative location, and means of transportation in the event of an extended outage. HMP&L cannot guarantee that there will be no interruption in electric service.

I UNDERSTAND that it is solely my responsibility to notify HMP&L anytime there is an interruption of service at my address and to advise them of the use of life-sustaining medical equipment.

I UNDERSTAND that it is NOT the purpose of the Critical Needs Program to prioritize restoration of electric services.

I UNDEERSTAND that HMP&L is in no way responsible for providing immediate restoration of service or any source of emergency power.

I UNDERSTAND that approval in the Program is for twenty-four (24) months only and that in order to continue to participate in the Program, I must reapply thereafter and provide HMP&L with the required documentation.

Customer's Signature: _____ Date: _____

HMP&L Use Only: Approved: Yes: ☐ No: ☐

Received By: _____ Date: _____ Response Date: _____