TOWN OF FRONT ROYAL

UTILITY SERVICE
SERIOUS MEDICAL CONDITION
CERTIFICATION FORM

The Town of Front Royal recognizes that severe medical conditions can place a strain on your budget. This form is provided to offer customers with severe medical conditions the means to document the need for occasional payment extension. By completion of this form, a Town customer qualifies for two, non-consecutive thirty (30) day extensions of their utility payment. This form does not release a customer from utility payments, nor does it eliminate the possibility of eventual cut-off for non-payment. If you experience financial hardship, please contact the Town to work out a payment arrangement at (540) 635-7799 or visit our Administration Building. This form is valid for one year from the date of approval by the Town.

To Be Completed By The Customer:		**Date:**
Customer Name:		Utility Account Number:
Customer Address:		Telephone Number:
		Alternate Phone Number:
City:	State:	Zip Code:
Patient Name:	Relationship to Customer:	
I certify that the information provided above is accurate, and the patient is the customer or a family member of the customer residing at this residence		
Customer Signature:		Date:

To Be Completed by the Director of the Warren County Department of Health:	
Medical Condition Qualifies: ☐	Medical Condition Does Not Qualify: ☐
I certify that the above patient has a serious medical condition, which is defined as a physical or psychiatric condition that requires medical intervention to prevent further disability, loss of function, or death. Such conditions are characterized by a need for ongoing medical supervision or the consultation of a physician. A serious medical condition carries with it a risk to health beyond that experienced by the majority of children and adults in their day-to-day minor illnesses and injuries. Individuals with a serious medical condition may require administration of specialized treatments and may be dependent on medical technology such as ventilators, dialysis machines, enteral or parenteral nutrition support, or continuous oxygen. Medical interventions may include medications with special storage requirements, use of powered equipment, or access to water. I certify that the preceding is correct.	
Director Signature:	*Date:*

To Be Completed by the Town:	
Received By:	Date:

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SERIOUS MEDICAL CONDITION
MEDICAL HISTORY FORM

To Be Completed by the Patient/Legal Guardian/Attorney in Fact	
Patient Name:	Customer Name:
Telephone Number:	Relationship to Customer:
Physician Name:	Physician Phone Number:
I hereby authorize and request my physician to release the following information about the above-named patient to the Warren County Department of Health and to answer related questions to help determine if the identified medical conditions meet the definitions of a serious medical condition, which is defined below. I certify that the patient lives at the address listed above and that all information provided is accurate.	
Patient/Legal Guardian/Attorney in Fact Signature:	Date:

To Be Completed by the Physician:	
Physician Name:	Physician Telephone Number:
Physician Address:	Physician Fax Number:
	Physician Email:
Patient's Diagnosis/Serious Medical Condition:	
Equipment Prescribed and/or Required Treatment for Condition:	
Expected Duration of Condition:	
Additional Comments:	
I certify that the above patient has a serious medical condition, which is defined as a physical or psychiatric condition that requires medical intervention to prevent further disability, loss of function, or death. Such conditions are characterized by a need for ongoing medical supervision or the consultation of a physician. A serious medical condition carries with it a risk to health beyond that experienced by the majority of children and adults in their day-to-day minor illnesses and injuries. Individuals with a serious medical condition may require administration of specialized treatments and may be dependent on medical technology such as ventilators, dialysis machines, enteral or parenteral nutrition support, or continuous oxygen. Medical interventions may include medications with special storage requirements, use of powered equipment, or access to water. I certify that the preceding is correct.	
Physician Signature:	*Date:*