New Mexico

90-Day Financial & Medical Certification Forms

Purpose

Customers with a documented medical condition may be eligible to obtain medical certificates that allow Xcel Energy to suspend credit action such as late fees and disconnect notices for 90 days. During this suspension, customers are encouraged to set up pay arrangements and/or seek energy assistance.

Customers may also be eligible for extended medical certifications, which suspend disconnection for up to one year. Even when an extended medical certification is authorized, financial recertification is required every 90 days.

INSTRUCTIONS

Financial Certification Form

Section I and Section II must be completed by the primary Xcel Energy account holder, as listed on the utility bill, **and** the administering authority, unless the account holder is self-certifying.

Section III must be completed by the administering authority, such as the Department of Human Services (HSD) or a tribal authority. Section II is not applicable to customers who are self-certifying.

Section IV must be completed by the primary account holder and must include a copy of the account holder's current Medicaid eligibility.

Medical Certification Form

Section V must be completed by the patient with a serious or chronic illness, as defined by Rule 17.5.410.7 NMAC, or the patient's legal guardian.

Section VI must be completed by the primary Xcel Energy account holder, as listed on the utility bill.

Section VII must be completed by a physician or medical doctor (MD), physician assistant (PA) or nurse practitioner (NP).

To request 90-day financial and medical certificates, please be sure to follow the instructions below and complete the form in full. **All of the information requested in this form is required and must be valid and legible.** Failure to complete and submit the form, including medical professional's signature, may result in disconnection of utility services.

If authorized to receive extended medical certifications, complete and submit sections I-III, as defined above, every 90 days. Customers with a vision disability may contact Xcel Energy to request notifications in alternate formats when recertification is required.

If you have questions regarding this form, please call the Personal Account Department of Xcel Energy at **800-331-5262**.

Please return this form directly to Xcel Energy.

Fax: **612-564-7626**

Email: PAR@xcelenergy.com

Mail:
Xcel Energy
Attn: PAR Department
1800 Larimer St.
Denver, CO 80202

This certification is valid for 90 days, beginning the date of the medical professional's signature.

Rule 17.5.410.7 NMAC defines a serious or chronic illness as 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 substantial risk of death or gravely impair health.

If you need help paying your utility bills, we can help.
Please visit xcelenergy.com/EnergyAssistance or call 800-895-4999 to find energy assistance programs available in your area.

You may also contact United Way at **211** to be connected with community-based organizations that may provide additional bill payment assistance.

New Mexico

Clear form

Financial Certification

Note: in order to continue receiving gas or electric service from Xcel Energy, both a completed financial certification form and a completed medical certification form must be submitted.

Section I: Authorization to release information & acknowledgement of certification

I _____ authorize the administering authority to release information from my file to Xcel Energy, as
NAME OF PRIMARY ACCOUNT HOLDER
deemed necessary for the purpose of qualifying for the medical certification program.

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 Xcel Energy. I understand Xcel Energy cannot guarantee uninterrupted utility service and that I am responsible for making alternate arrangements in the event of an outage.

I certify that I have read and understand the purpose and instructions on this form, and that the information provided in this form is true and correct. I understand if I provide false information, I can be denied continued medical emergency gas or electric utility service.

Primary account holder's signature _____

Xcel Energy account number_____ Account holder's social security number (SSN) _____–____–_____

Account holder's phone number _____

Service address (as listed on the utility bill)_____ City_____ State _____ ZIP _____

Section II: Communication & outage contact preference (to be completed by the account holder)

Please provide complete and accurate contact information so Xcel Energy can reach you in advance of a planned power shutoff or unplanned outage (those situations may include severe weather, wildfire mitigation or other emergency situations).

Phone number _____

Type: ☐ Mobile ☐ Landline Permission to text: ☐ Yes ☐ No

Email _____

Contact for deaf/hard of hearing customers using TYY at phone number_____
TYY is a specialized telecommunication device for the deaf or hard of hearing.

Communication preference : ☐ Call ☐ Text ☐ Email ☐ TTY

NOTE: Xcel Energy is increasingly implementing wildfire safety settings on its powerlines during high wildfire threat conditions. Under these settings, outages may be extended as powerlines must be visually inspected after the increased period of risk has passed, in some cases only during daylight hours, before reconnection to ensure it is safe to restore power. If you are dependent on a powered medical device, you need to have a backup power plan to respond to longer potential outages.

By providing your contact information above you are giving permission to Xcel Energy to share your contact information with organizations such as state and local emergency first response agencies so they may aid both you and Xcel Energy during an extended outage to support your safety and well-being.

Section III: 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 guidelines as defined
PRIMARY ACCOUNT HOLDER'S NAME AND SSN
by the administering authority (such as Low-Income Home Energy Assistance Program (LIHEAP) assistance).

Agency representative's signature _____

Contact number _____ Fax number _____ Date _____

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Section IV: Self-certification (to be completed by the primary account holder)

If self-certifying, attach a copy of current New Mexico Medicaid eligibility for the primary utility account holder.

I _____ hereby certify that I am the person responsible for the charges for gas or electric utility service
PRINTED NAME OF PRIMARY ACCOUNT HOLDER

at _____ and that a seriously or chronically ill person (as defined by Rule 17.5.410.7 NMAC),
SERVICE ADDRESS

_____ resides at the premises listed above.
PATIENT'S NAME

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

Primary account holder's signature _____

Xcel Energy account number_____ Account holder's social security number (SSN) ___ ___ _____

Account holder's phone number _____

Service address (as listed on the utility bill)_____ City _____ State_____ ZIP_____

This certificate is valid for 90 days. 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 Xcel Energy to make pay arrangements and explore additional energy assistance options.

Rule 17.5.410.7 NMAC defines a serious or chronic illness as 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 substantial risk of death or gravely impair health.

Medical Certification

Note: in order to continue receiving gas or electric service from Xcel Energy, both a completed financial certification form and a completed medical certification form must be submitted.

Section V: To be completed by the patient or patient's legal guardian

I _____ hereby authorize the medical professional signing this certification to disclose the information
PRINTED NAME OF PATIENT

contained in this Medical Certification Form to Xcel Energy.

I certify the information provided in this form is true and correct. I understand if I provide false information, I could be denied continued medical emergency gas or electric utility service from Xcel Energy.

Patient or legal guardian's signature _____ Date _____

Section VI: To be completed by the primary account holder (as shown on the utility bill)

I _____ hereby certify that I am the person responsible for the charges for gas/or electric utility service
PRINTED NAME OF PRIMARY ACCOUNT HOLDER

at _____ and that a seriously or chronically ill person (as defined by Rule 17.5.410.7 NMAC) resides at the
SERVICE ADDRESS

service address listed above.

I further certify that I will immediately notify Xcel Energy or arrange to have such notification provided, if 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 that renders continued medical emergency gas and/or electric utility service unnecessary.

Primary account holder's signature _____ Date _____

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Section VII: Medical professional use only

Medical professional's name _____ Date _____

Facility address _____ License/NPI number _____

Phone number _____ Fax number _____

I certify that I am (check one):

☐ A licensed physician or physician assistant accepted by the New Mexico Medical Board and practicing under the New Mexico Practice Act.

☐ An osteopathic physician or osteopathic physician assistant practicing under the New Mexico Osteopathic Physician's Practice Act.

☐ A certified nurse practitioner licensed by the New Mexico Board of Nursing and practicing under the New Mexico Nursing Practice Act.

I certify that the patient listed below has the following condition(s), which qualify as a serious or chronic illness pursuant to Rule 17.410.7 NMAC.

Patient's name _____ Date of last exam _____

Service address (as listed on the utility bill)_____ City_____ State _____ ZIP _____

Utility service type (check one) ☐ Gas ☐ Electric ☐ Both

Condition(s) and reason(s) for continued gas and/or electric utility service (if applicable, list medically necessary equipment) _____

_____

_____

_____

Signature of medical professional _____ Date _____

Medical Professional use only – Extended Medical Certification (valid for one year)

For patients meeting the requirements for extended medical certification, please also complete the section below.

I certify that the above-mentioned patient's medical condition, as listed above, is permanent and will not improve within 12 months from today's date.

Medical professional's signature _____ Date _____

Rule 17.5.410.7 NMAC defines a serious or chronic illness as 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 substantial risk of death or gravely impair health.

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