NYSEG
An Avangrid company

NYSEG life-sustaining equipment identification survey

If you or someone in your household uses electrically powered, life-sustaining equipment, you may be eligible for our life-sustaining equipment identification program. Please complete section I and make sure your doctor completes section II before returning your completed survey to us at: NYSEG, P.O. Box 5240, Binghamton, NY 13902.

Section I – To be completed by the person whose name appears on the NYSEG bill

NYSEG account information:

Name as it appears on NYSEG bill: _____

Street address and city: _____

Mailing address (if different): _____

Do you live alone? _____

Daytime phone: (___)_____ Evening phone: (___)_____ Cell phone: (___) _____

(Please note: Before a power interruption occurs, have at least one phone (corded or battery powered) available for use that is not dependent upon electricity. Remember: Cordless phones and digital phone service do not work during a power interruption.)

NYSEG account number: _____

Life-sustaining equipment user information:

Name of life-sustaining equipment user: _____

Life-sustaining equipment user's year of birth:_____

Relationship to the person whose name appears on the NYSEG bill: _____

Life-sustaining equipment information:

If there is a power interruption for 24 hours or more, I have the following to use as a back-up (check all that apply and provide details):

Generator – type:_____ Number of hours it will last: _____

Battery – type: _____ Number of hours it will last: _____

Medicine – type:_____ Number of hours it will last: _____

Oxygen tanks – type: _____ Number of hours it will last: _____

Other / manual – type: _____ Number of hours it will last: _____

Where is the life-sustaining equipment located in the home? _____

Name of life-sustaining equipment supplier: _____

Personal home health care:

Does the life-sustaining equipment user receive personal home health care?_____

Name of agency providing home health care:_____

Agency providing home health care phone: (___)_____ _____

Number of hours per week care:_____

24 hour emergency plan:

In the event of an extended power interruption, it's important to have a plan for a 24-hour period without electricity. Please describe your plan: _____

_____

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Please note: During widespread electrical outages, NYSEG Customer Advocates, the Public Service Commission (PSC), and Emergency Operations Center (EOC) work together to protect the well-being of all of our customers, specifically those who use life-sustaining equipment. Upon request NYSEG will provide local EOCs with your information to ensure your safety.

If relocation is necessary, where will you go?

Street address and city: _____

Whose residence or facility is this? _____

Phone at the above location: (____) _____

What is the name and phone number for your nearest:

Hospital: _____ Phone: (____) _____

Fire or rescue department:_____ Phone: (____) _____

Please provide names and phone numbers of people we can contact who may know your whereabouts if we are unable to reach you during a power interruption:

Name:_____Relationship to you:_____

Street address and city: _____

Phone at address: (____) _____ Cell phone: (____) _____

Signature of person whose name appears on the NYSEG bill:

_____Date: _____

Section II - Doctor information

Doctors, please complete the information below or register and certify the customer's medical emergency at: nyseg.com/medical/login.jsf.

Medical information:

What is the illness of the life-sustaining equipment user?_____

What are the life-sustaining equipment user's physical limitations? _____

Please select one of the qualifying Life-Sustaining Equipment:

- ☐ Aspirator / Suction Machine
- ☐ Feeding Tube
- ☐ Home Dialysis Machine
- ☐ Oxygen Concentrator (24 Hour Oxygen)
- ☐ Ventricular Assist Device (VAD, LVAD, RVAD, BIVAD)
- ☐ Ventilator
- ☐ Apnea Monitors For Infants
- ☐ Cuirass Respirators
- ☐ Intravenous Feeding Machines
- ☐ Intravenous Medical Infusion Machines
- ☐ Respirators
- ☐ Other: _____

Doctor information:

Name:_____ Phone: (____)_____

NYS registration number _____

Signature of Doctor: _____ Date: _____