



Power Safety Shutoff Resources Application



Rev.1.21

Date Completed: _____

Full Name: _____ Email: _____

Mailing Address: _____ Phone: _____

City: _____ Zip Code: _____ County: _____

Physical Address, City, Zip Code, and County *(if different from above)*

What type of electric assistive technology or durable medical equipment do you use?

How many hours a day do you use each of the devices you listed to the left?

Do you live alone? Yes No

If the power were to go out at your home, do you have any backup source of electricity to use?

Yes No

If yes, what type of backup electricity?

Are you on the [Medical Baseline Program](#)? Yes No

Do you have a personal household emergency plan? Yes No

If no, are you willing to work on and use it? Yes No

Are you receiving or eligible for any type of public benefits? Yes No

Who is your electricity provider?

What type of PSPS

assistance do you need?

What is the best time of day to reach

you to discuss and review your application?