Power Safety Shutoff Resources Application

Rev.7.21

Date Completed: _____

Full Name: _____ Email: _____

Mailing Address: _____

City: _____ Zip Code: _____ County: _____

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

_____

Contact Number: _____ Phone Type: ◯ Landline ◯ Cell Phone

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 is your electricity account number? (optional) _____

Do you pay your utility bills, or are they included in your rent payment? ☐ Yes ☐ No ☐ Unsure

What time of day can we call to discuss your disaster/emergency/PSPS needs? _____

How did you hear about the DDAR program? _____