Power Safety Shutoff Resources Application

Rev.6.20

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

What type of PSPS assistance do you need? _____

What is the best time of day to reach you to discuss and review your application? _____