

Priority Response – Emergency Medical Program

Do you use life-support equipment?

South Hadley Electric Light Department works hard to provide reliable electric service to all customers. We understand it is especially important for customers that have life support equipment at home.

If life support equipment is used at your residence and dependent on electric service, you can apply for Priority Response status on your location. Eligibility criteria for Priority Response status includes:

- Active SHELD electric service at location;
- Individual requiring life support equipment resides at service location;
- Completion of an annual Emergency Medical Certification form with input from a registered medical provider;
- SHELD approval

When a customer is approved by SHELD for Priority Response status, a tag is placed on the wire or transformer servicing the location to ensure that field personnel know critical medical equipment is in use at the residence. Customers with Priority Response status on their account also receive advanced notice for scheduled outages, when possible, and severe storm watches and warnings with the potential to cause extended outages, i.e., severe thunderstorms, hurricanes, tropical storms, tornados, blizzards, heavy snow, and ice storms.

We will do everything we can to provide a safe and reliable electricity supply. Please note, registering as a life support customer does not guarantee continuous 24-hour power supply to the premise or early service restoration in the event of an outage. Despite our best efforts, electric lines are vulnerable to storms, lighting, and motor vehicle accidents. We strive to restore service efficiently for all customers, but especially to those on the Priority Response list. In the event of widespread outages, however, our crews must work in an orderly manner when restoring service, and we may not be able to provide priority restorations to your location. Therefore, SHELD strongly suggests that customers who depend on electrical equipment for a medical necessity have emergency plans in place in case the power goes out for an extended period of time. These plans may include a back-up power source, extra medical supplies or an alternate location until the outage is over.

Please call Customer Service at 413-536-1050 if you have any additional questions. The Priority Response – Emergency Medical form is available for download on our website: www.sheld.org.



South Hadley Electric Light DEPARTMENT

Priority Response - Emergency Medical Certification Please print or type all the information

To be completed by customer:

Patient's Name: _____

SHELD Customer Name: _____

Account Service Address: _____

SHELD Account #: _____

Method of Contact for Potential Outage Notification

(Please supply information for all the ways you would like us to contact you)

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Text Message: _____

E-Mail: _____ Alternate E-Mail: _____

Please read and answer the following:

1. What electrically powered device is medically necessary to sustain the life of the patient?

Nebulizer for asthma, lung

Feeding (Pump) Machine

Oxygen Machine

Heart Monitor

Infant Apnea Monitor

Ventilator/Respirator

Home Dialysis Treatment

Other, Please Describe: _____

2. How frequently is this device(s) used?

Weekly: Once a week Several times per week

Daily: Once Daily Twice a day Every few hours Hourly Constantly

As necessary: _____

3. Does this device solely rely upon electrical power to operate? Yes No

4. Does this device have a battery backup? Yes No

5. Does the residence or building in which the device is operated have a backup generator?
 Yes No

6. Is this device portable? Yes No

7. Is the patient physically restricted to the residence or building? Yes No

8. Does the patient have a support system to assist them in relocating in the event of a sustained power outage?
 Yes No



South Hadley Electric Light DEPARTMENT

Priority Response – Emergency Medical Certification

___ I certify that the patient named above is a member of my household residing at the above address.

___ I understand that, if approved, SHELD will attempt to notify me in the event of planned outages and severe impending storms.

___ I understand SHELD will make every effort to prioritize my location when restoring power whenever it is reasonably possible, and that in the event of a widespread outage, early service restoration is not a guarantee.

___ I understand that the supply of power is not guaranteed, and if my need for electricity is high, that I should have plans for the patient should power become unavailable, which may include, but not limited to, battery backup, emergency generation, and a support system for the relocation of the patient to an alternate location with power.

___ I understand that this in no way releases me from my obligations to pay my monthly bill in accordance with the MA Department of Public Utilities standard payment terms.

___ I understand that it is my responsibility to notify SHELD if the patient moves, or the patient’s conditions changes.

___ I understand that this certification will expire one year from the date of approval and must be resubmitted annually by this date to continue participating in the Priority Response – Emergency Medical program.

SHELD Customer Signature: _____ Date: _____

Information below to be completed by a MA Licensed Healthcare Provider:

I certify that I have examined the patient name above and, in my professional opinion as a medical doctor, physician’s assistance, nurse practitioner, or advanced-practice registered nurse licensed by the Commonwealth of Massachusetts, I certify that my patient requires the electrically-dependent medical device stated above, and that the device can be solely operated under electrical power.

(A detailed explanation for reasons not mentioned above must be submitted for review)

Health Care Provider Name (please print): _____
Circle one that applies: Medical Doctor Physician’s Assistant Nurse Practitioner Advanced-Practice RN

MA Medical License Number: _____

Office Address: _____

Office Phone Number: _____

Health Care Provider Signature: _____ Date: _____

Note: Both pages of this SIGNED form must be emailed (kfrazier@sheld.org) from the office of the MA-licensed healthcare provider directly to South Hadley Electric. Hand delivered forms will not be accepted. Thank you for your cooperation in this regard.