NUECES COUNTY
WATER CONTROL AND IMPROVEMENT
DISTRICT #3

MEDICAL COURTESY NOTICE PROGRAM

The Nueces County Water Control and Improvement District 3 (District) strives to supply its customers with an uninterrupted source of water. It is especially critical to our customers who have certain medical conditions. With that in mind, the District documents those customers who have advised us of the need for special circumstances due to a medical condition in the home.

If your account becomes delinquent due to non-payment, the Medical Courtesy Notice Program will provide you with a 24-hour notice before services are scheduled to be disconnected. This additional time should be used to contact the District, so that payments may be made.

To qualify, the District account holder must complete a program application stating whether the account holder or a family member, living in the home, requires special medical consideration. The application must be completed by both, the account holder and their designated physician. The application will include, but is not limited to, the following information.

- The account holder's name, address, telephone and account number.
- Existing medical condition in the home.
- Name of person and relation to account holder for which the service is medically required.
- The doctor's name, address, telephone and license number.

For more information on this and other programs available by the Nueces County Water Control and Improvement District 3, please call (361) 387-4549.

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Medical Courtesy Notice Program

IMPORTANT NOTICE: *Acceptance into the Medical Courtesy Notice Program does not guarantee continous water service. This program only extends disconnection of water service twenty-four (24) hours so that a payment and/or payment arrangements can be made.*

To be completed by Water District Customer:					
Last Name		First Name		Account#	
Address					
City		State		Zipcode	
Phone		Email			
Name of Person for which water service is medically necessary:					
How is this Person related to account holder:					
Physician Name:			Physician Phone:		

Authorization: I hereby authorize any release of any medical information pertinent to my qualifing as a medical customer with Nueces County WCID #3. By signing below, applicant acknowledges the accuracy and truth of the information provided. I also, authorize a representative of Nueces County WCID #3 , if needed, to contact the above named physican to veryfiy any informatio proviced on this application.

Signature of Patient/Legal Guardian:		Date:	

To be Completed by Physician:

Please check below applicable conditions for above named patient, for which continued water service is necessary:

Is the patient bed-ridden? ☐ Yes ☐ No

Is continuous water service necessary for any type of life sustaining equipment? ☐ Yes ☐ No

If yes, please explain the type of equipment:

Is the patient's condition temporary? ☐ Yes ☐ No

If yes, estimated time period when condition would warrant ther removal from this program:

Addtiional comments:

Physician's Name :		Signature:	
Address:			
City, State, Zip		Date:	

Please Mail to: Nueces County WCID3, P O Box 1147, Robstown, TX 78380 or Fax to: 361-387-4711

FOR OFFICE USE ONLY: ☐ APPROVED ☐ DENIED BY: Date: