NEBRASKA
DEPT. OF ENVIRONMENT AND ENERGY

State of Nebraska Weatherization Assistance Program

Priority Conditions for Cooling Assistance

FORM
WX30

Date: _____ Job Number: _____
Patient Name: _____ SSN Number: _____
Date of Birth: _____

Your patient may be eligible for cooling assistance/air conditioner assistance if your patient "Has a severe illness or condition which is aggravated by extreme heat as verified by a medical statement" (476 NAC 2-003). This would typically be an illness/condition of threat to life, limb, or of marked impact on quality of life. The illness/condition should be aggravated by extreme heat and improved with cooling. It cannot be simply for comfort or convenience.

Please review the Priority Conditions for Cooling Assistance list below and check the boxes for each of the illnesses/conditions that meet the severity or life-threatening requirement for your patient. Each identified illness/condition requires information to be completed to indicate how long the illness/condition is expected to continue.

Please note: Some of the letters have specific illness/condition listed below them. Your patient must have one of those conditions checked to meet the eligibility requirement for that category of illnesses/conditions. Thus, the form must be fully completed and returned for accurate eligibility determinations to be made.

If none of the conditions in letters A through O apply to your patient, but your patient has an illness/condition or is taking a medication you believe meets the guidelines of or makes the patient susceptible to a severe or life-threatening medical condition that is worsened by heat; please complete letter P (Other). In letter P, you must identify what the illness/condition is, explain how it meets the severity or life-threatening requirement/why cooling is necessary, and inform how long the illness/condition is expected to continue.

Please return the completed form to the patient to submit to their local Weatherization Service Provider for Weatherization Cooling Repair/Replacement Assistance.

PRIORITY CONDITIONS FOR COOLING ASSISTANCE

A. Chronic cardiovascular disease (check all that apply):
- ☐ With congestive heart failure (CHF)
- ☐ With symptomatic arteriosclerotic heart disease (ASHD), coronary artery disease, etc.
- ☐ With moderate to severe hypertension

Please indicate how long this illness/condition is expected to continue:

☐ One year (qualifying condition for one cooling season) ☐ Lifelong ☐ Other: _____

B. Hypertension (check all that apply):
- ☐ That is poorly controlled, especially with diastolic greater than 90 on medication
- ☐ That has resulted in previous end organ damage to heart, brain, kidneys or eyes (retinae)
- ☐ That is moderately well controlled with medication but in conjunction with medication poses a significant threat to health with heat exposure
- ☐ On Diuretic medication

Please indicate how long this illness/condition is expected to continue:

☐ One year (qualifying condition for one cooling season) ☐ Lifelong ☐ Other: _____

C. ☐ Cerebral vascular accident in past (stroke victim) or risk with cerebral vascular disease

Please indicate how long this illness/condition is expected to continue:

☐ One year (qualifying condition for one cooling season) ☐ Lifelong ☐ Other: _____

D. ☐ Diabetes being treated with daily insulin or oral hypoglycemic medication

Please indicate how long this illness/condition is expected to continue:

☐ One year (qualifying condition for one cooling season) ☐ Lifelong ☐ Other: _____

E. ☐ Heat exhaustion or heat stroke in the past

Please indicate how long this illness/condition is expected to continue:

☐ One year (qualifying condition for one cooling season) ☐ Lifelong ☐ Other: _____

F. Cancer patient who is (check all that apply):

☐ Terminally ill

☐ Severely ill, receiving chemotherapy and/or radiation therapy

Please indicate how long this illness/condition is expected to continue:

☐ One year (qualifying condition for one cooling season) ☐ Lifelong ☐ Other: _____

G. Chronic severe respiratory disease (check all that apply):

☐ Severe chronic or frequently recurrent asthma requiring long term daily medication

☐ Severe chronic obstructive pulmonary disease (COPD)

☐ Permanent tracheostomy

☐ Severe emphysema

Please indicate how long this illness/condition is expected to continue:

☐ One year (qualifying condition for one cooling season) ☐ Lifelong ☐ Other: _____

H. ☐ Seizures that are known to be aggravated by heat and now being treated with daily medications

Please indicate how long this illness/condition is expected to continue:

☐ One year (qualifying condition for one cooling season) ☐ Lifelong ☐ Other: _____

I. Severely handicapped person who must be cared for by others (check all that apply):

☐ Severe burn victim

☐ Body cast/body brace

☐ Severe cerebral palsy

☐ Quadriplegic

Please indicate how long this illness/condition is expected to continue:

☐ One year (qualifying condition for one cooling season) ☐ Lifelong ☐ Other: _____

J. Severe mental condition that may be aggravated by heat, and the patient is taking the following medication (check all that apply):

☐ Lithium

☐ Anti-Parkinson

☐ Phenothiazine

☐ Amitriptyline

☐ Anticholinergic

Please indicate how long this illness/condition is expected to continue:

☐ One year (qualifying condition for one cooling season) ☐ Lifelong ☐ Other: _____

K. ☐ Acquired immunodeficiency syndrome (AIDS) or AIDS-related complex (ARC)

Please indicate how long this illness/condition is expected to continue:

☐ One year (qualifying condition for one cooling season) ☐ Lifelong ☐ Other: _____

L. ☐ Newborn with a monitor

Please indicate how long this illness/condition is expected to continue:

☐ One year (qualifying condition for one cooling season) ☐ Lifelong ☐ Other: _____

M. ☐ Sickle cell anemia

Please indicate how long this illness/condition is expected to continue:

☐ One year (qualifying condition for one cooling season) ☐ Lifelong ☐ Other: _____

N. ☐ Severe dermatitis requiring intense daily therapy

Please indicate how long this illness/condition is expected to continue:

☐ One year (qualifying condition for one cooling season) ☐ Lifelong ☐ Other: _____

O. ☐ Multiple Sclerosis

Please indicate how long this illness/condition is expected to continue:

☐ One year (qualifying condition for one cooling season) ☐ Lifelong ☐ Other: _____

If the patient has an illness/condition not listed above that you believe meets the requirements for cooling assistance, complete letter P below. This section must be thoroughly completed for possible approval.

NOTE: The following, on their own, do not meet the requirements for cooling assistance:
Adenoid/Tonsillar Hypertrophy, ADHD, Anxiety, Allergies, Atopic Dermatitis, Autism, Back Pain, Bipolar Disorder, Chronic Pain, Depression, Epistaxis, Fibromyalgia, Headaches, Heart Palpitations, Healthy Baby, Obesity, Pain worsens when patient is hot, Uncomplicated Pregnancy, PTSD, or Rhinitis.

P. ☐ OTHER: (illness/condition must be severe and aggravated by extreme heat)
Illness/Condition (describe severity):

Describe why cooling is needed for this condition:

Please indicate how long this illness/condition is expected to continue:

☐ One year (qualifying condition for one cooling season) ☐ Lifelong ☐ Other: _____

If the NDEE is unable to determine if the illness/condition and its severity meet the requirements based on the information provided on this form, additional medical documentation may be requested.

Signature of M.D., D.O., P.A., or APRN: _____ Title: _____

For P.A. or APRN, Name of the Supervising Physician: _____ Title: _____

☐ Check this box if you are an APRN and practice independently without a supervising physician.

Provider Name (please print clearly): _____

Office Name: _____

Office Address: _____ City/Zip Code: _____

Office Telephone Number: _____ Date: _____