WATER SERVICE DISCONNECTION EXEMPTION

CITY OF ROSEVILLE CALIFORNIA Utilities

1. Primary Account Holder/Customer on Account

Last Name _____ First Name _____

Home Address _____ Phone Number _____

City _____ State _____ Zip _____

Mailing Address if different than above _____

Utility Account Number _____ XXX-XX-_____ Last 4 digits of your SSN

2. Income Documentation

Income eligibility can be verified through any of the following:

- ☐ Previous year's tax return

OR

Proof of participation in any of the following programs:

- ☐ CalWORKs
- ☐ CalFresh
- ☐ General assistance
- ☐ Medi-Cal
- ☐ Supplemental security income/state supplementary payment program
- ☐ California special supplemental nutrition program for women, infants and children

Eligibility requirements

Service cannot be discontinued if all of the following conditions are met related to income and health status:

- A primary care provider certifies that the discontinuation of residential service will be life threatening or pose a serious threat to the health and safety of a resident.
- Resident meets income eligibility requirements.
- Resident enters into a payment agreement, with respect to all delinquent charges.

Income Guidelines

You must have a combined household income no greater than specified in this chart based on the number of household members.

Household Members	Annual Gross Income*
1	$21,300
2	$24,350
3	$27,400
4	$30,400
5	$32,850
6	$37,190
7	$41,910
8	$46,630

*Annual gross income as identified by the U.S. Department of Housing and Urban Development (HUD) by Placer County. Gross income includes, but is not limited to, the sum of all wages including: Social Security, Welfare, retirement payments, disability payments, interest, self-employment and dividend income for all residents living in the household, excluding dependent minors under the age of 18.

3. Statement of certification completed by a medical doctor

To be eligible for disconnection exemption, a primary care provider must certify that the discontinuation of residential water service will be life threatening or pose a serious threat to the health and safety of a resident. Please have page two completed by your primary care provider and include with this application.

4. Agreement and Signature

I understand that if I become past due on my utility bill, my water service is subject to disconnection. I understand that it is my responsibility to contact the City of Roseville Finance Department to discuss payment arrangements prior to the final due date, as indicated in the Reminder Notice.

I understand that the information provided on this application will be used to verify and determine program eligibility. I hereby authorize the City of Roseville to verify the information provided on this application with any source and to share the information on this application with the City's Finance and Water Departments. **Please allow up to 60 days for processing.**

I understand it is my obligation and responsibility to report any changes in assistance program participation or increases to my household income; and should my household income exceed the income qualification level and or, when the person requiring the medical equipment either no longer uses the device or resides at this location my participation will be canceled.

By signing below, I declare under the penalty of perjury that the information contained on this application is true and correct.

X _____ Date _____

5. Sign, date and mail all required documents to:

City of Roseville - Electric Department
116 South Grant St, Suite 100 Roseville, CA 95678
(Do not include this application with bill payment)

WATER SERVICE DISCONNECTION EXEMPTION

CITY OF ROSEVILLE CALIFORNIA Utilities

Statement of Certification - To be completed by a Medical Doctor

To be eligible, a patient must depend on an essential medical support device. Such a device is defined as any medical device requiring utility supplied water for its operation and which is regularly required to support the life of any person residing in a residential dwelling. Examples include home dialysis machines or other such equipment.

In your opinion, does the equipment listed here meet this description? (Please circle) YES NO

Patient Name

Type of Equipment required

Make/Model

Doctor's Name

Address

Phone

California Medical License Number

I hereby certify, under penalty of perjury, that this patient regularly requires the use of the listed life supporting medical equipment that is dependent on water service.

Signature

Date