CITY OF ANTIOCH

Water Department

200 H Street, Antioch, California 94509-1285

Telephone: (925) 779-7060

Alternative Payment Arrangement Application Form

Service Address: _____

Water Account Number: _____

Account Holder Information

First Name: _____ **Last Name:** _____

Mailing Address ***(if different from service address)*****:** _____

Email: _____ **Home Phone:** _____ **Cell Phone:** _____

Customer Signature: _____ **Date:** _____

Per California Senate Bill 998, the City shall not discontinue residential water service if ALL of the following conditions are met:

1. **Health Condition** – discontinuation of residential water service will be life threatening to or will pose serious threat to the health and safety of a resident of the premises.
    - *Certification of Primary Care Provider Form must be completed and submitted with the application*
2. **Financial Inability –** current recipient of CalWorks, or CalFresh, Medi-Cal, or Supplementary Security Income/State Supplementary Payment Program, or California Special Supplemental Nutrition Program for Women, Infants, and Children, or declares that the household's annual income is less than 200 percent of the federal poverty level application in California. (https://www.healthforcalifornia.com/covered-california/income-limits)
    - *Applicable government documents must be provided (statements of benefit, income declarations require tax return verification)*
3. **Alternative Payment Schedule –** customer is willing to enter into a written agreement for deferred or reduced payment schedule.
    - *Note that failure to keep up with the payment agreement will cause disconnection of water service unless past due amount is paid in full.*

The City will determine if customer meets ALL of the conditions upon receipt of documentation. City requests for additional information from the customer must be provided within two (2) business days. The City will notify customer in writing if they do not meet the conditions and shall inform them of impending discontinuation of water service within five (5) business days.

********** FOR WATER STAFF ONLY **********

__ Verify & Approve Health Care Provider Form Date Received _____ By _____

__ Verify & Approve Financial Eligibility Date Approved _____ By _____

__ Complete & Sign Written Payment Agreement