



MEDICALLY DISABLED WATER RATE PROGRAM APPLICATION AND DOCTOR'S CERTIFICATION FORM

HOW TO QUALIFY AND APPLY

Under Marin Water's Medically Disabled Water Rate Program (6.01.100), the bimonthly service charge and watershed management fee are waived, and qualifying customers receive an additional twelve (12) CCFs of water billed at the tier one rate (one CCF, or hundred cubic feet, is 748 gallons).

To qualify, you must:

1. Establish your disability **requiring use of additional amounts of water related to the disability** through doctor verification (form attached);
2. Be a **separately metered** district single-family or multi-unit residential customer not served through a master meter;
3. Use per billing period an average in excess of the amount of water specified in Section 6.01.025 for Billing Code 1 at Tier 1;
4. Install water-efficient showerheads, toilets, and faucet aerators in your home that comply with Marin Water requirements Code (free showerheads and aerators are available from Marin Water).

RENEWAL PROCESS

- If the Doctor of Medicine or Osteopathy, licensed to practice medicine in the State of California, certifies the **medical condition is permanent**, Marin Water requires completion of a form every four (4) years self-certifying the customer's continued eligibility for the Medically Disabled Water Rate program.
- If the Doctor of Medicine or Osteopathy, licensed to practice medicine in the State of California, certifies the **medical condition is not permanent**, Marin Water requires completion of a new application including a qualified medical practitioner's certification every two (2) years or following the date of recovery, whichever period is shorter. Following expiration of the two (2) year period or date of recovery, new application must be submitted for further consideration and enrollment in the program.

To apply, please fill out the attached application form and return it to:

**Marin Municipal Water District
Customer Service Department
P.O. Box 994
Corte Madera, CA 94976**

If you have any questions about this program or other discount programs available, please contact Customer Service at **415-945-1400** or visit **marinwater.org/discounts**. We will notify you in writing as to whether or not you qualify for this program.

Please note: The District reserves the right to request additional information at any time. Participation in the program may be revoked if a customer does not meet all qualifying criteria as set forth herein and in the District Code.



MARIN WATER Code Section 6.01.100 (C): "The district may perform a water audit on any property of a customer receiving the water rate for people with disabilities water rate to assure that the customer is in compliance with this section and other provisions in this code pertaining to water conservation."



MEDICALLY DISABLED WATER RATE PROGRAM APPLICATION AND DOCTOR'S CERTIFICATION FORM

Complete ALL steps 1-3 below. Incomplete applications will be denied and require resubmission resulting in the delay of acceptance. The Medically Disabled Water Rate Program is not retroactive. Customers who qualify will begin receiving the rate during the billing cycle following approval of their application.

Application for calendar year 20_____

1. Customer Information:

Customer Name:		Application Date:
Service Address:		Phone:
Customer #:	City:	Zip:
Mailing Address (if different):	City:	Zip:

2. Certification of Doctor of Medicine or Osteopathy, Licensed to Practice Medicine in the State of California

All questions (a-c) below must be completed:

- a. I certify the medical condition and needs of my patient: _____
Full Time-Resident with Medical Condition (First Name and Last Name)
- b. The patient above, requires the heightened use of water related to their medical disability? ☐ Yes ☐ No
- c. The condition is: ☐ Permanent ☐ Temporary; If temporary, anticipated recovery date: _____
(the medical rate will be discontinued to align with the above designated recovery date)

Doctor's name (please print or type) _____

Doctor's signature _____

Office address _____

City, state, zip _____ Phone Number _____

3. Customer Declaration and Application Checklist – CONTINUED ON BACK PAGE



MEDICALLY DISABLED WATER RATE PROGRAM APPLICATION AND DOCTOR'S CERTIFICATION FORM

3. Customer Declaration and Application Checklist, please read and agree to the following terms:

- ☐ I am a **separately metered** District single-family or multi-unit residential customer not served through a master meter (apartment complexes or mobile home parks with a master meter do not qualify), and my use per billing period on average is in excess of the amount specified in Section 6.01.025 of the District Code for Billing Code 1 at Tier 1.
- ☐ I acknowledge that Marin Water cannot guarantee uninterrupted water service. I am responsible for making alternate arrangements in the event of a water outage.

I declare under penalty of perjury that the foregoing is true and correct. I agree to notify Marin Water promptly if the above named patient/qualified full-time resident moves or no longer qualifies for the Medical Disabled Water Rate Program.

Customer's Signature: _____ **Date:** _____

Submit application:

Email: customerservice@marinwater.org OR US Mail to: Marin Water, PO Box 994 Corte Madera, CA 94976



MEDICALLY DISABLED WATER RATE SELF-CERTIFICATION RENEWAL APPLICATION FORM

Complete ALL steps 1-3 below. Incomplete applications will be denied and require resubmission resulting in the delay of acceptance or renewal. To avoid delays in renewal or possible removal from the program, please make sure your request is complete and timely submitted. Failure to timely submit your renewal application prior to the deadline to recertify will result in removal from the program and no retroactive billing adjustments will be made.

Application for calendar year 20_____

1. Customer Information:

Customer Name:		Application Date:
Service Address:		Phone:
Customer #:	City:	Zip:
Mailing Address (if different):	City:	Zip:

2. Self-Certification Declaration and Checklist, please read and agree to the following terms:

I understand and agree that: _____
Full Time-Resident with Medical Condition (First Name and Last Name)

- ☐ The above named person is a full time resident at the listed service address, with a qualified medical condition, established through Doctor of Medicine or Osteopathy verification, requiring use of additional water related to such medical condition.
- ☐ The **medical condition is permanent**, as established through Doctor of Medicine or Osteopathy verification on my original application. Marin Water requires completion of a renewal application form every four (4) years self-certifying the customer's continued eligibility for the Medically Disabled Water Rate program.
- ☐ I am a **separately** metered district single-family or multi-unit residential customer not served through a master meter (apartment complexes or mobile home parks with a master meter do not qualify), and my use per billing period on average is in excess of the amount specified in Section 6.01.025 of the District Code for Billing Code 1 at Tier1.
- ☐ I acknowledge that Marin Water cannot guarantee uninterrupted water service. I am responsible for making alternate arrangements in the event of a water outage.
- ☐ I agree to notify Marin Water promptly if the qualified resident moves or no longer qualifies for the Medical Disabled Water Rate Program.

3. I declare under penalty of perjury that the foregoing is true and correct.

Customer's Signature: _____ **Date:** _____

Send completed application: Email: customerservice@marinwater.org **OR** US Mail to: Marin Water, PO Box 994 Corte Madera, CA 94976-0994

