Scotts Valley Water District Board of Directors

Medical Needs Flat Rate Agreement

Your Name: _____ Name on Account: _____

Service Address: _____ Account #: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Please describe specific activities that warrant need for exceptional water use for the documented medical need, with the date the need began and the estimated amount of time it will be needed:

_____

_____

_____

_____

1) A signed letter is required (sent directly to the District) from the attending (currently licensed in the State of California) medical professional that describes the prescribed medical need for exceptional water use for therapeutic, hygienic, and/or restorative purposes due to the diagnosed condition.

2) Any necessary water conservation criteria or retrofits as determined by a pre and post site inspection are required. (If you are found to be out of compliance with conservation criteria at a future time, you will be billed using regular tiered rates until compliance has been restored. Possible additional billing charges and/or interest may accrue.)

3) You must inform the District if the need for the special rate no longer exists. The Board of Directors may review eligibility annually (or more frequently if needed) and repayment and interest may be required if rate no longer applies.

4) Rates are subject to District's annual fiscal proportional adjustments. The current Qualifying Medical Rate remains effective until changed by ordinance of the Scotts Valley Water District Board of Directors.

Save and except for the specific provisions herein, the account holder remains subject to all ordinances, policies, rules and regulations of the Scotts Valley Water District in existence now, or subsequently adopted.

I have read, received a copy of, and understand the above requirements and conditions for securing and maintaining a flat commodity charge for the qualifying medical condition per SVWD Ordinance No. 158-12.

_____

Signature of customer or authorized legal representative Date

_____

Signature of District Board President Date

_____

Signature of District General Manager Date

_____ *(For office use only)* _____

Medical need letter from physician received on/from _____

Pre-inspection date/staff: _____ Post-inspection date/staff: _____

Board approval date/flat rate effective: _____ Cycle rate will first appear: _____

Date copies of signed agreement and ordinance sent to customer: _____

Year 1: _____Year 2: _____Year 3: _____Year 4: _____Year 5: _____ (rev 3/28/18)