

AVHCWD Monthly Payment Assistance Consideration Application

At Apple Valley Heights County Water District, we care about our customers. We are pleased to offer this application to assist you in requesting assistance with consideration of monthly water bills, payment plans, waiver of late fees or cessation of utility shut-off efforts.

If you qualify, please complete the application below and return to: Apple Valley Heights County Water District, Attn: Customer Service, 9429 Cerra Vista Street, Apple Valley, CA 92308.

New and existing applicants:

Please complete this form and return it to Apple Valley Heights County Water at the address above. Offered assistance is not retroactive; customers who qualify will begin eligibility in the month after application is received. If approved, you may qualify for waived late fees and/or waived disconnections; the Board of Directors will consider each application on a case-by-case basis

Program qualifications:

- The Apple Valley Heights County Water bill must be in your name.
- You must live at the address where the water is consumed.
- Your household must meet the income guidelines listed below OR someone in your household must be enrolled in one of the public assistance programs described below.
- You must notify Apple Valley Heights County Water if your household no longer qualifies for consideration of assistance.
- Following enrollment, you may be required to provide proof of eligibility.

Note to applicant: Please attached any additional information you feel is pertinent to your request. For questions, please e-mail AVHCWD@YAHOO.COM or call 760-247-7330.

1 CUSTOMER INFORMATION (please type or print)

New applicant Existing applicant

Customer Account Number: (Located on front of your Water bill)

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Name _____
As it appears on your water bill

E-mail _____

Service Address _____ City _____ CA Zip Code _____
Do NOT use a P.O. Box

Mailing Address _____ City _____ CA Zip Code _____
If different from the address above

Daytime Telephone Number _____
Please include area code

Home Cell

Total number of adults and children living in your household

Birth Date

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2 PLEASE CHOOSE BASIS FOR ELIGIBILITY (select A or B)

- A. Someone in my household is enrolled in one or more of the following assistance programs or impacted by another issue:
- Medicaid/Medi-Cal for Families A & B
 - Supplemental Security Income (SSI)
 - CalFresh SNAP
 - Women, Infants, & Children Program (WIC)
 - CalWORKs/Temporary Assistance for Needy Families (TANF)
 - COVID-19 (Coronavirus Related Issues)
 - Other (Please describe below): _____

- B. My household's annual income is less than 200% of the federal poverty level:
Your household's gross annual income may not exceed these LIA income guidelines. (effective June 1, 2019 – May 31, 2020)
- | | | | | | | | | |
|-------------------------------------|----------|----------|----------|----------|----------|----------|----------|----------|
| Total number of people in household | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| Total combined annual income | \$33,820 | \$33,820 | \$42,660 | \$51,500 | \$60,340 | \$69,180 | \$78,020 | \$86,860 |

3 DECLARATION (please read carefully and sign below) I state that the information I have provided in this application is true and correct. I agree to provide proof of eligibility if asked. I agree to inform Apple Valley Heights County Water District if I no longer qualify to receive any assistance considerations. I understand that if I receive assistance without qualifying for it, I may be required to pay back any past due balances or waivers received. I declare under penalty of perjury that all information provided on this form is true and correct.

X _____
Customer Signature fill in circle if guardian or power of attorney Date _____