CITY OF ARLINGTON

MEDICAID WAIVER FORM

AMBULANCE UTILITY FEE EXEMPTION APPLICATION

Applicant Name:____

Address:____

Phone:____

Birth Date:____

Utility Account Number:____

PLEASE ATTACH PROOF OF MEDICAID ELIGILITY

1. A copy of your current Medicaid ID card, or
2. A copy of a current Medicaid coupon, or
3. An award letter on DSHS letterhead.

CERTIFICATION: By signing this form I confirm that I:

Have provided all documentation to verify Medicaid eligibility. I understand the City may periodically require documentation to verify continued eligibility.

Declare under penalty of perjury that the information in this application is true and complete.

Understand it is my responsibility to notify the City of any change in circumstances.

If I received a waiver of the fee without meeting the qualification guidelines, I will be required to pay back the discount received.

___________________________________ ______________________________

Applicant Signature Date