



CITY OF RIVERBANK

661 3RD ST ▪ Riverbank, California 95367 ▪ Office 209.863-7109 Fax 209.863.7126

REQUEST FOR PAYMENT PLAN APPLICATION PROCEDURES

Dear Customer,

The City of Riverbank will offer you a payment plan for outstanding balances. Setting up a payment plan requires the following:

1. The City of Riverbank bill must be in your name.
2. You must live at the address.
3. Complete the Request for Payment Plan application. All sections must be completed.
4. Attached required documentation based on your circumstances.
 - a. For medical circumstances certification from a licensed primary care provider. A licensed primary care provider includes an internist, general practitioner, obstetrician-gynecologist, pediatrician, family practice physician, licensed physician's assistant, primary care clinic, rural health clinic, community clinic or hospital outpatient clinic.
 - b. Based on Household Income you must meet the HCD Annual Income Limits currently in effect at the time of your application is submitted. You must verify the household gross annual income by submitting:
 - Last year's tax return (1040, 1040A, or 1040-EZ) including all Schedules C and E filed with the return.
 - Social Security/pension benefits statement, SSI letter, which is obtained by calling 1-800-772-1213
 - Two most recent paystubs (if applicable)
 - Copies of any other source of income documents.

***Note:** For your protection, please **hide or remove the first five digits of any Social Security number** on anything you submit.*
 - c. Based on a member of an eligible program you must submit evidence of one of the following programs: CalWORKs, CalFresh, general assistance, Medi-Cal, Supplemental Security Income/State Supplementary Payment Program, and California Special Supplemental Nutrition Program for Women, Infants and Children.
 - d. Based on other circumstances you must submit the detail of the circumstances behind the request for a payment plan in the area provided on the page 3 of the application packet.
5. Complete the time frame of the payment plan and the monthly payment being requested.
6. **During a payment arrangement all other utility charges accruing during any subsequent billing period must remain current. If subsequent billings become delinquent, the account will become subject to disconnection and payment for entire balance due prior to reconnection.**
7. Application must be signed.

FOR MORE INFORMATION

Call (209) 863-7109 Email: finance@riverbank.org



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REQUEST FOR PAYMENT PLAN APPLICATION

Customer Name: _____ Account Number: _____

Telephone: _____ Email: _____

Service Address: _____

Mailing Address: _____

*Please use this form if you have received notice that your water account at the above address is past due and subject to discontinuation. To receive a payment plan and avoid discontinuation of service, you must choose one of the options below **and initial each requirement applicable to you.***

_____ **Option 1: I have special medical AND financial circumstances (Complete all items below)**

_____ Attach a certification from a licensed primary care provider* stating that discontinuation of water service will be life threatening or pose a serious threat to the health and safety of a resident living at the above address;

_____ Certify that you are unable to pay for service within the normal payment period. You may satisfy this requirement in one of two ways:

_____ (1) Please mark here if your household's annual income meets the program income guidelines shown in the table below. Proof of income is required.

Payment Plan Income Guidelines

Number of Persons in Household	Household Annual Income (all income sources before taxes)
1	\$27,900 or less
2	\$31,900 or less
3	\$35,900 or less
4	\$38,850 or less
5	\$43,050 or less
For each additional person add:	\$3,200

_____ (2) Please mark here and attach proof if a current member of your household participates in one of the programs listed below**; **AND** agree to participate in a payment plan, which may include an extension, amortization agreement, or alternative payment schedule with respect to all charges that are delinquent.

*Attach certification from licensed primary care provider. A licensed primary care provider includes an internist, general practitioner, obstetrician-gynecologist, pediatrician, family practice physician, licensed physician's assistant, primary care clinic, rural health clinic, community clinic or hospital outpatient clinic.

**Eligible programs are: CalWORKs, CalFresh, general assistance, Medi-Cal, Supplemental Security Income/State Supplementary Payment Program, and California Special Supplemental Nutrition Program for Women, Infants and Children.



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___ **Option 2: I have other circumstances that prevent me from being able to pay my bill at this time**

___ Detail the circumstances behind the request for a payment plan in the area provided on the page 3 of the form.

___ Agree to participate in a payment plan, which may include an extension, amortization agreement, or alternative payment schedule with respect to all charges that are delinquent.

Continue Request for Payment Plan

Customer Name: _____ Account Number: _____

Please detail the circumstances behind the request for a payment plan:

Please provide the requested time frame for the extension and monthly payment being requested:

of Months _____ **Monthly payment amount \$** _____

CERTIFICATION

BY SIGNING BELOW, I DECLARE UNDER PENALTY OF PERJURY THAT THE FACTS CONTAINED WITHIN THIS REQUEST FORM ARE TRUE AND CORRECT. I UNDERSTAND THAT I MAY BE REQUIRED TO PROVIDE ADDITIONAL DOCUMENTATION NEEDED TO PROCESS THIS FORM.

Signed: _____ Date: _____

Printed Name: _____ Best Contact Phone #: _____

Customers may only enter into an extension payment or alternate payment if there are no other current arrangements. During a payment arrangement all other utility charges accruing during any subsequent billing period must remain current. If subsequent billings become delinquent, the account will become subject to disconnection and payment for entire balance due prior to reconnection.



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***** FINANCE DEPARTEMNT USE ONLY *****

FORM RECEIVED DATE: _____

BY (STAFF MEMBER): _____

_____ **APPROVED**

_____ **DENIED**

Determination made by: _____ **Date:** _____

If approved agreed upon terms:

of Months: _____

Monthly Payment amount: \$ _____

Date of first payment: _____

Day of month following payments to be made on: _____

_____ **Letter to customer outlining the arrangements**

_____ **Contract has been placed on Utility Account**