



Medicaid-Eligible Ambulance Utility Fee Exemption Application – Qualifications & Instructions

QUALIFICATIONS:

To qualify for the Medicaid In-Home Care Ambulance Utility Fee Exemption, you must meet the following requirements:

1. Are a resident of the City of Lynden
2. Are Medicaid-Eligible
3. Receive in-home care services at the utility service address
4. Agree to renew this application annually
5. Provide proof of eligibility
 - a. A copy of the resident's current State of Washington Medicaid card.
6. Provide proof of in-home care services
 - a. A copy of the approval letter from Medicaid. This is the most current award letter from DSHS authorizing State covered in-home care services.

INSTRUCTIONS:

To apply, please complete the following:

1. Complete the enclosed application form. PRINT or TYPE all information except your signature.
 - a. The application form can also be obtained on the City of Lynden website or by requesting a form from the Fire Department Office.
2. Read the Affidavit **prior to signing the application.**
3. Return the signed application with the required attachments to:

Lynden Fire Department
215 4th Street
Lynden, WA 98264

CHANGES IN ELIGIBILITY:

You are required to notify the City in writing if there are any changes in your Medicaid eligibility or receiving in-home services during the year while you are receiving an Ambulance Utility Fee exemption. You cannot receive the exemption at more than one address. If you move to another address in the City, please let us know so your information can be transferred to that account.



Medicaid-Eligible Ambulance Utility Fee Exemption Application

Applicant's Name (Last, First, Middle)

Residence Address

Suite/Apt. #

Mailing Address (if different from Residence Address)

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Phone Number with Area Code

Birth Date (MM/DD/YYYY)

Utility Account Number

Affidavit: I declare under penalty of perjury under the laws of the State of Washington that I have read the instruction sheet and that all of the statements, as marked, are true and correct. Falsification of any information on this application will result in loss of eligibility for further program assistance and repayment of the exemption received as a result of providing false information. I consent and agree that the City of Lynden may verify and confirm the attached documents if deemed necessary and the Department of Social and Health Services is authorized to release my information from their files. I understand I must notify the City of Lynden immediately of any change of circumstances.

- I have read and understand the Affidavit.
- I have attached a copy of the State of Washington Medicaid card.
- I have attached a copy of the approval letter from Medicaid (most current award letter from DSHS authorizing State covered in-home care services).

Applicant's Signature

Date