CITY OF LYNDEN
2015
Medicaid-Eligible
Ambulance Utility Fee Exemption Application

_____
Applicant's Name

_____
Address

_____
Address

_____
Phone Number with Area Code

_____
Birth Date

_____
Utility Account Number

PLEASE ATTACH PROOF OF ELIGIBILITY.

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.

Important: Read before signing:

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.

_____ _____
Applicant's Signature Date