FORM 998-A

Certification of Primary Care Provider

THIS SECTION TO BE FILLED OUT BY ACCOUNT HOLDER

Account Number	Service Address
Account Holder Name	Person Receiving Primary Care
Date of Bill seeking Payment Arrangement	Amount of Bill seeking Payment Arrangement

I, the account holder, certify under penalty of perjury that the above-named person receiving primary care resides at the service address.

Account Holder Signature	Phone Number

THIS SECTION TO BE FILLED OUT BY PRIMARY CARE PROVIDER

Name of Primary Care Provider	Name of Clinic or Medical Facility
Clinic Address	Clinic Phone Number
National Provider Identifier	Person Receiving Primary Care

I, the primary care provider, certify under penalty of perjury that I provide care to the above-named person and that discontinuation of water service to this person would pose a serious threat to his or her health and safety.

Primary Care Provider Signature

THIS SECTION TO BE FILLED OUT BY CITY STAFF