



## **Requirements for Medicaid-Eligible In-Home Care** **Medic 1 Utility Rate Exemption**

*Medicaid-Eligible In-Home Care Exemption* – provides a Medic 1 Utility rate exemption for Medicaid-eligible utility customers who receive in-home care services. This is consistent with the exemption requirement in Engrossed Substitute House Bill 1635 that passed in 2005.

### **The Medic 1 Rate Exemption Requirements:**

- A. Are a resident of the City of Port Angeles.
- B. Are Medicaid-eligible.
- C. Receive in-home care services at the utility service address.
- D. *Do not live in a licensed care facility that receives a Medic 1 Utility discount.*
- E. Agree to *Renew application yearly.*
- F. ***Verify Medicaid-eligibility; 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.
- G. ***Verify the use of in-home care; PLEASE ATTACH PROOF OF SERVICES.***
  - 1. A recent invoice, or
  - 2. A letter from a care provider on letterhead with a current date.

## **Instructions for Completing the Application Form**

1. Please PRINT or TYPE all information except your signature.
2. **It is important that you read the affidavit on the application carefully before you sign the application.**
3. Return the completed application and supporting documentation as soon as possible to City Hall. If you have any problem completing the application, you may contact Customer Services, 457-0411, for assistance.
4. **The Application Form can be filled out two ways. Print out the forms and fill out by hand, or by typewriter. Sign and return to City Hall.**

### ***Please Note:***

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 a Medic 1 Utility rate exemption. You ***cannot*** receive the Medic 1 Utility rate exemption at more than one address. If you move to another address in the City, please let us know so your credit can be transferred to that account.



## Medicaid-Eligible In-Home Care Medic 1 Utility Rate Exemption Application

1. \_\_\_\_\_  
Applicant's Name Last, First, Middle
2. \_\_\_\_\_  
Residence Address Apt. #
3. \_\_\_\_\_  
Mail Address (Only if different from your residence address)
4. \_\_\_\_\_  
Phone Number with Area Code
5. Month/ Day/ Year/ \_\_\_\_\_  
Applicant's Birthday Applicant's Social Security Number
6. \_\_\_\_\_  
Utility Account Number

### **Important: Read before signing:**

**Affidavit:** I swear under penalties of either civil or criminal perjury that I have read the instruction sheet and that all of the statements, as marked, are true. Falsification of any information on this application will result in loss of eligibility for further program assistance and repayment of all funds received as a result of providing false information.

The date you write here must be the same date you mail or deliver this application to the City.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
Applicant's Signature (Do Not Print)