

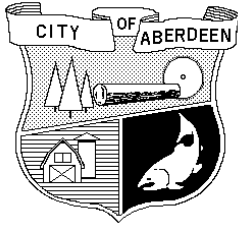
## Requirements for Medicaid-Eligible In-Home Care EMS Utility Fee Exemption

*Medicaid-Eligible In-Home Care Exemption* – provides an EMS 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.

Medicaid-Eligible In-Home Care is defined as care provided by a caregiver paid by the State of Washington.

### EMS Rate Exemption Requirements:

- A. Are a resident of the City of Aberdeen.
- 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 an EMS Utility discount.
- E. Agree to *Renew the application yearly*.
- F. *Verify Medicaid-eligibility (CNP - Categorically Needy Program)*.  
**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 copy of your most current award letter from DSHS authorizing State covered in-home care services. (This can be obtained from your social worker.)



**CITY OF ABERDEEN**  
**Medicaid-Eligible In-Home Care**  
**EMS Utility Fee Exemption**

Application

***PLEASE PRINT***

\_\_\_\_\_  
Applicant's Name (Last, First, Middle)

\_\_\_\_\_  
Residence Address Apt. #

\_\_\_\_\_  
Mailing Address (Only if different from your residence address)

\_\_\_\_\_  
Phone Number with Area Code

\_\_\_\_\_  
Month/ Day/ Year/  
Applicant's Birth Date

\_\_\_\_\_  
Utility Account Number

**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 Aberdeen 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 Aberdeen immediately of any change of circumstances.

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

\_\_\_\_\_  
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. The Application form can be obtained by printing the form from the website or requesting a form from the Ambulance Billing Office at 360-537-3261. If you need assistance completing the application call the Ambulance Billing Office.**
- 4. Return the signed application with the required documents to Aberdeen Fire Department, 700 West Market Street, Aberdeen, WA.**

### ***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 an EMS Utility rate exemption. You **cannot** receive the EMS 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.