CERTIFICATION OF PRIMARY CARE PROVIDER

C.O.W. FORM 998-A

ACCOUNT HOLDER INFORMATION

The section below to be filled out by the C.O.W. Utility Account Holder

ACCOUNT NUMBER	**SERVICE ADDRESS**
ACCOUNT HOLDER NAME	**PERSON RECEIVING PRIMARY CARE**
Date of bill requesting payment arrangement	**Amount of bill requesting Payment Arrangement**

ACCOUNT HOLDER CERTIFICATION

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

PRIMARY CARE PROVIDER CERTIFICATION

The section below to be filled out by Primary Care Provider

PATIENT NAME	**NAME OF PRIMARY CARE PROVIDER**
CLINIC NAME	**CLINIC ADDRESS**
CLINIC PHONE NUMBER	**NATIONAL PROVIDER IDENTIFIER**

PRIMARY CARE PROVIDER CERTIFICATION

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

FOR OFFICE USE ONLY

DATE AND TIME RECEIVED	RECEIVED BY	COMPLETE?