

ALTOONA WATER AUTHORITY
Medical Hardship Certificate

Name and Address of Ratepayer:

For Office Use Only:

Account Number	Delinquent amount \$
Date Issued:	Down Payment: (20%)
Date Received:	Monthly payment not including current bill:
Expiration Date:	

Notice to Ratepayer:

Water service may be shut off at _____ within 7 days of the above date issued unless this certification has been completed, signed by a physician and returned to our customer service department.

Physician Certification – Please Read Carefully and Fill in Completely

I Certify, that in my professional opinion:

1. The following person has an injury or medical condition that significantly impairs one or more bodily functions:
2. The absence of municipal water and or sewer service at the above-referenced property during the 30 days that this certification is valid would pose a **serious** and **immediate threat** to health or safety.

Please Print or Type:

Name of Afflicted:		Age:	Sex: M F
Relationship to Ratepayer:		Anticipated Length of Affliction (Max. 30 days):	
Nature of Illness:		Date of Last Exam:	
Specific Reason For Which Absence of Municipal Water Service Would Aggravate Condition:			
Physician's Name:		Physician's Phone #:	
Physician's Address:			
Physician's Signature (Personal Signature Required):			

Ratepayer Financial Certification – Please Read Carefully and Sign

I, the ratepayer listed above, hereby certify that a financial hardship exists and I am financially unable to pay the Altoona Water Authority water and sewer bill in full at this time. I understand **that I am obligated to make reasonable payment arrangements** with the Authority for the balance currently owed, and if I do not do so on time, or if I do not abide by such arrangements, water service may be discontinued. I also understand that I am responsible for paying all future charges for water and sewer service as they become due.

I hereby verify under penalty of perjury that the information provided herein is accurate and true to the best of my knowledge.

Ratepayer's Signature (Personal Signature Required):	Date:
------------------------------------------------------	-------

Note!
THIS CERTIFICATE IS IN EFFECT FOR THE ANTICIPATED LENGTH OF THE ILLNESS NOT TO EXCEED 30 DAYS.
FOR QUESTIONS PLEASE CONTACT (814) 949-2540