



**CAP Program**

# Customer Assistance Program Application

The San Bernardino Municipal Water Department's Customer Assistance Program provides a water discount of \$5.00 per month for single family residential customers who qualify.

1. Complete the application and list all members of your household.
2. Send a copy of **ALL proof of income for last year** on each household member.
3. Return application and proof of income to Water Department Customer Service:

Mail completed form to:  
S.B.M.W.D.  
CAP Program  
P.O. Box 710  
San Bernardino, CA 92402

Or bring to:  
Water Department Customer Service  
City Hall Building, 5<sup>th</sup> Floor  
300 N. D Street  
San Bernardino, CA 92418

## Water Account Information

\_\_\_\_\_

Water Account Number

\_\_\_\_\_

Service Address (Number & Street Name)

\_\_\_\_\_

First Name

\_\_\_\_\_

MI

\_\_\_\_\_

Last Name

( )

\_\_\_\_\_

Phone Number (Required)

\_\_\_\_\_

Social Security Number

\_\_\_\_\_

Date of Birth

List **all** household members:

Age:

Source of Income:

Amount:

1. Applicant (person on water account)	Age:	Source of Income:	Amount:
2.			
3.			
4.			
5.			
6.			
7.			
8.			

By signing the application, I verify that all information provided is true and correct.

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

For Office Use Only:

Date Received	CSR	ID Type	Income Doc.	YES / NO Eligible	Effective Date



# Customer Assistance Program

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## WHO IS ELIGIBLE?

- |  | <u>Yes</u>               | <u>No</u>                |
|--|--------------------------|--------------------------|
| ▶ I am the customer of record and live within the service territory of the SBMWD...                          | <input type="checkbox"/> | <input type="checkbox"/> |
| ▶ The service location is my primary residence...<br>(My mailing address is the same as the service address) | <input type="checkbox"/> | <input type="checkbox"/> |
| ▶ I meet the annual household income criteria & can provide acceptable documentation...                      | <input type="checkbox"/> | <input type="checkbox"/> |
- 
- | <u>HOUSEHOLD SIZE*</u> | <u>INCOME</u> | <u>Acceptable Documentation</u>  |
|------------------------|---------------|--|
| 1                      | \$23,300      | - Latest Federal Income Tax Return<br>- Latest State Income Tax Return<br>- Social Security Benefit Statement<br>- Previous Year SSI Disability Award letter<br><br>*Household size determined by dependents claimed in income tax |
| 2                      | \$26,650      |  |
| 3                      | \$29,950      |  |
| 4                      | \$33,300      |  |
| 5                      | \$35,950      |  |
| 6                      | \$38,650      |  |
| 7                      | \$41,300      |  |
| 8                      | \$43,950      |  |
- 
- |   |                          |                          |
|---|--------------------------|--------------------------|
| ▶ My service is for a single family residence... (No duplexes, triplexes, or other multi-family accounts) | <input type="checkbox"/> | <input type="checkbox"/> |
|---|--------------------------|--------------------------|

If you have answered yes to all the questions above you may qualify for the CAP Program...



## APPLICATION PROCESS

To be accepted for program review, applicant must submit:

1. Thoroughly completed application
2. Must be filled out accurately
3. Appropriate documentation must be submitted with application
4. SBMWD reserves the right to determine validity of documentation
5. Provide personal identification

- ▶ The CAP Program will become effective the billing period after which the application is received and approved
- ▶ CAP participation is for a two year term, program eligibility expires after 2<sup>nd</sup> year anniversary date
- ▶ Applicants must re-apply every two years
- ▶ This program is on a first come, first served basis, and available based upon funding