CITY OF RIO VISTA
201 S. HWY 174 - P.O. BOX 129
RIO VISTA, TX 76093
P: (817) 373-2588 / F: (817) 373-2988

Water Application

Security Deposit:	$125.00
Connection Fee:	$30.00

Water

Water bills are due on the 10th of each month or date specified on your water card. A late fee of $15.00 will be added after the due date. A reconnection fee of $60.00 will be applied if water is shut off for non-payment. Returned checks will be charged an additional $30.00 fee.

Trash

Trash service is included in the water bill at $13.99 per month. The trash is picked up each Monday (exceptions occur on some holidays). Trash needs is to be set out by 7:00 a.m. on Monday morning to insure pick-up. Garbage cans are recommended. ALL trash must be in bags. Limbs need to be stacked neatly by the curb.

Careflight Application / Opt out Forms

A fee of $1.00 per month will be charged to your water bill for the Careflight membership program. Information discussing this program is attached. Please fill out the attached membership form completely. We can submit this for you. If you would like to Opt-Out then you will need to complete the Opt-Out form.

**The Careflight membership only pertains to air transportation and/or hospital to hospital transport if Careflight is the carrier. AMR is the service covering Johnson County for ground transportation.

Prairieland Fee

A fee of $2.00 per month will be charged to your bill for the Prairieland fee. This fee is to cover water being pumped into the city for residents.

Rio Vista Water Department

FOR OFFICE USE ONLY:

ACCOUNT #________________

SEQ____________

GARBAGE____ SEWER____

WATER____ SEPTIC____

METER READING:________________

SERVICE APPLICATION & AGREEMENT

MOVE IN DATE:____________________ **DATE:**____________________ **# IN HOME:**____________ **CHOOSE ONE:**RENT____ OWN____

APPLICANT OR COMPANY NAME (First, Middle & Last):____

DRIVERS LICENSE # OF APPLICANT (*COPY OF DL IS NEEDED*): ____

ADDRESS AT WHICH APPLICANT REQUEST SERVICE:____

____

CHECK ONE: ACREAGE:______ **SITE-BUILT HOME:**______ **DOUBLE WIDE:**_____ **SINGE WIDE:**_____ **DUPLEX/QUAD:**_____

BILLING ADDRESS:____

PHONE: PRIMARY ______________________________ **ALTERNATIVE:** ______________________________

EMAIL: ____**E-BILLING: YES:**______**NO:** __________

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CO-APPLICANT/SPOUSE NAME:____

PHONE: PRIMARY ______________________________ **ALTERNATIVE:** ______________________________

EMAIL: ____**E-BILLING: YES:**______**NO:** __________

DRIVERS LICENSE # OF CO- APPLICANT (*COPY OF DL IS NEEDED*): ____

The following information is requested by the Federal Government in order to monitor compliance with Federal Laws prohibiting discrimination against applicants seeking service. You are not required to furnish this information, but are encouraged to do so. This information will not be used in evaluating your application or to discriminate against you if your choose not to furnish it. We are required to note race/national origin of individual applicants on the basis of visual observation or surname.

☐ **WHITE**	☐ **HISPANIC**	☐ **AMERICAN INDIAN / ALASKAN NATIVE**	☐ **MALE**
☐ **BLACK**	☐ **ASIAN / PACIFIC ISLANDER**	☐ **OTHER**	☐ **FEMALE**
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City of Rio Vista

Customer Service Agreement

I. PURPOSE. The City of Rio Vista WATER SYSTEM is responsible for protecting the drinking water supply from contamination or pollution which could result from improper system construction or configuration on the retail connection owner's side of the meter. The purpose of this service agreement is to notify each customer of the restrictions which are in place to provide this protection. The public water system enforces these restrictions to ensure the public health and welfare. Each retail customer must sign this agreement before the City of Rio Vista WATER SYSTEM will begin service. In addition, when service to an existing retail connection has been suspended or terminated, the water system will not re-establish service unless it has a signed copy of this agreement.

II. RESTRICTIONS. The following unacceptable practices are prohibited by State regulations.

A. No direct connection between the public drinking water supply and a potential source of contamination is permitted. Potential sources of contamination shall be isolated from the public water system by an air-gap or an appropriate backflow prevention device.

B. No cross-connection between the public drinking water supply and a private water system is permitted. These potential threats to the public drinking water supply shall be eliminated at the service connection by the installation of an air-gap or a reduced pressure-zone backflow prevention device.

C. No connection which allows water to be returned to the public drinking water supply is permitted.

D . No pipe or pipe fitting which contains more than 0.25% lead may be used for the installation or repair of plumbing at any connection which provides water for human use.

E. No solder or flux which contains more than 0.2% lead can be used for the installation or repair of plumbing at any connection which provides water for human use.

III. SERVICE AGREEMENT. The following are the terms of the service agreement between the City of Rio Vista WATER SYSTEM (the Water System) and _____(the Customer).

A. The Water System will maintain a copy of this agreement as long as the Customer and/or the premises is connected to the Water System.

B. The Customer shall allow his property to be inspected for possible cross-connections and other potential contamination hazards. These inspections shall be conducted by the Water System or its designated agent prior to initiating new water service; when there is reason to believe that cross-connections or other potential contamination hazards exist; or after any major changes to the private water distribution facilities. The inspections shall be conducted during the Water System's normal business hours.

C. The Water System shall notify the Customer in writing of any cross-connection or other potential contamination hazard which has been identified during the initial inspection or the periodic re-inspection.

D . The Customer shall immediately remove or adequately isolate any potential cross-connections or other potential contamination hazards on his premises.

E. The Customer shall, at his expense, properly install, test, and maintain any backflow prevention device required by the Water System. Copies of all testing and maintenance records shall be provided to the Water System.

IV. ENFORCEMENT. If the Customer fails to comply with the terms of the Service Agreement, the Water System shall, at its option, either terminate service or properly install, test, and maintain an appropriate backflow prevention device at the service connection. Any expenses associated with the enforcement of this agreement shall be billed to the Customer.

CUSTOMER'S SIGNATURE: _____ DATE: _____

ADDRESS: _____

_____

City of Rio Vista

AUTOMATIC BANK DRAFT AUTHORIZATION FORM

Please complete the following information and mail, fax or email this form to the City of Rio Vista at the address or fax number listed below. Please provide a voided check with this completed form.

_____

Printed Customer Name(s) shown on City of Rio Vista Account Statement

_____

City of Rio Vista Utility Account Number

_____

Service Address

_____

City State Zip Code

_____

Bank Name Name(s) listed on the Bank Account

_____

Bank Account Number / Routing Number

_____ _____

Daytime Phone Number **Evening Phone Number**

Check one: ( ) Checking Account ( ) Savings Account

I authorize the City of Rio Vista Utilities to debit (draft) the account identified above each month for the amount of services billed on my water utility account. Additionally, I authorize my financial institution identified above to debit the same amounts from my account. I understand that this authorization will be in effect until I notify the City of Rio Vista Utilities and my bank, in writing, that I no longer desire this service. I also understand that if corrections in the debit amount are necessary, it may involve an adjustment (credit or debit) to my utility account.

_____ _____

Customer Signature **Date**

201 S. HWY 174
P.O. BOX 129 – RIO VISTA, TEXAS 76093
PHONE (817) 373-2588 / FAX (817) 373-2988
CITYHALL@RIOVISTATX.COM

YOU CAN NOW REQUEST THAT PERSONAL INFORMATION RETAINED IN OUR UTILITY RECORDS NOT BE RELEASED TO UNAUTHORIZED PERSONS

The Texas legislature enacted a bill, effective September 1, 1993 allowing utility districts to give their customers the option of making the customer's address, telephone number, and social security number confidential.

IS THERE A CHARGE FOR THIS SERVICE?

NO. There is not a charge for this service.

HOW CAN YOU REQUEST THIS?

Simply complete the bottom of this page and return to:

City of Rio Vista
P.O. Box 129
Rio Vista, TX 76093

Your response is not necessary if you do not want this service.

WE MUST STILL PROVIDE THIS INFORMATION UNDER LAW TO CERTAIN PERSONS.

We must still provide this information to (1) an official or employee of the state or a political subdivision of the state, or the federal government acting in an official capacity; (2) an employee of a utility acting in connection with the employees duties; (3) a consumer reporting agency; (4) a contractor or subcontractor approved by and providing services to the utility or to the state, a political subdivision state, the federal government, or an agency of the state or federal government; (5) A person for whom the customer has contractually waived confidentiality for personal information; or (6) another entity that provides water, wastewater, sewer, gas, garbage, electricity, or drainage services for compensation. However, such confidentiality does not prohibit the City from disclosing the name and address of each customer on a list to be made available to the City's voting customers, or their agents or attorneys, in connection with any meeting of the City's customers.

Yes, I want to make my personal information (address, telephone number, and social security number confidential.

_____ NAME

_____ ACCOUNT NUMBER

_____ ADDRESS

_____ TELEPHONE NUMBER

_____ CITY, STATE, ZIP

X_____ SIGNATURE

CareFlite
Making precious minutes count since 1979

3110 S. Great Southwest Pkwy.
Grand Prairie, Texas 75052
(877) 339-2273 Membership
Fax: 972-660-8821

Caring – Heart Membership Application City of Rio Vista Water

The City of Rio Vista and CareFlite have partnered together to allow all customers of the water system to become members of CareFlite for $1 per month. This includes all permanent family members of your household at no additional cost as listed below.

First Name: _____ Middle Initial: _____ Last Name: _____

Home/Mailing Address: _____

City: _____ Zip Code: _____ Phone # (_____) _____

Date of Birth: _____ □ Male □ Female Email _____

Do you have health insurance? □ Yes □ No If you answered Yes to this question, please list your primary health insurance company:

_____

Other Family Members of Your Household:

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ □ Male □ Female

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ □ Male □ Female

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ □ Male □ Female

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ □ Male □ Female

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ □ Male □ Female

(For additional household family members, please copy this page and attach to this application)

By submitting this application, I agree (on my behalf and on behalf of my family) in consideration of the benefits provided to abide by the terms of the Caring-Heart Membership Program, which are shown on the back of this application. I request payment of authorized Medicare or other insurance benefits to me, or on my behalf, to be paid to CareFlite for any emergency services and supplies furnished to me or my household family members by CareFlite. I authorize any holder of any of my medical information or that of my household family members to release that information to CMS, its agents or carriers, or CareFlite in order to determine benefits payable on my behalf or on behalf of my family members, now and in the future. This agreement and authorization is executed on my own behalf and on behalf of the other members of my household, if they are minors or otherwise unable to sign. **I understand that under Texas rule 157.11 if I or a household member is a Medicaid recipient, than I am not allowed to have them on this application.** Therefore I am stating that I have not listed on this application anyone that is a Medicaid recipient. If a household family member subsequently becomes a recipient of Medicaid, I will notify CareFlite in writing of this change immediately. I warrant that all of the information on this application is true and correct. CareFlite reserves the right to request documentation to verify the accuracy of any such information. I acknowledge that membership in CareFlite's Caring-Heart Membership Program is an EMS membership in a program sponsored by CareFlite and is not a membership in CareFlite's non-profit entity as the term "membership" is contemplated under the Texas Non-Profit Corporation Act.

_____

Signature

For CareFlite Office Use Only

Date Received: _____ Membership # Assigned: _____

3110 S. Great Southwest Pkwy.
Grand Prairie, Texas 75052
Members Services Office
(877) 339-2273
Fax: 972-660-8821

Caring - Heart Membership Program

PERSONS COVERED: This Agreement covers the household family members listed on the application on the reverse side provided to CareFlite, so long as they remain full-time residents (including college students) of my household. New residence family members may be added, others deleted or the household location changed by written notice to CareFlite at the address shown above. Added members will be effective as of the date the information is received by CareFlite. Medicaid recipients may not enroll by law.

EFFECTIVE DATE: The program will be effective on the date the customer starts their utility service with the City of Rio Vista and pays their $1 per month membership fee for CareFlite's Caring-Heart membership.

BENEFITS: Payment of the membership fee and compliance with the terms of this program/agreement entitles the member to the following benefits:

1. Emergency helicopter air ambulance services originating within 150 miles of DFW Airport for medically necessary advanced or basic life support emergency transport services from CareFlite as a result of an emergency medical condition shall pay nothing out of pocket, unless otherwise specified herein.
2. Emergency fixed wing air ambulance services for patients needing a higher level of care originating within 500 miles of DFW Airport and within the United States shall pay nothing out of pocket. For non-medically necessary fixed wing transports, CareFlite will make its best efforts to obtain an insurance pre-authorization. For fixed wing air ambulance service that are not medically necessary and/or operated for patient or family convenience, CareFlite will give members a 50% discount from its standard rates.
3. CareFlite's ground ambulance and 911/EMS service will be available with its service areas. These benefits will follow the rules of this Air Ambulance membership program.
4. If CareFlite has any agreements for the reciprocal honoring of a membership benefit with other air/ground EMS providers, all Members of CareFlite shall be covered by such agreement. A list of any such agreements can be found at www.careflite.org .

PAYMENT FOR SERVICES: I understand that I am responsible for payment for any services provided to me by CareFlite, but that my membership will assist me by discharging that part of my financial liability that is not covered by insurance for those CareFlite services specified in this Agreement. This benefit is subject to certain limitations specified in this agreement. As a condition of receiving this benefit, I hereby assign (hand over) to CareFlite all rights and benefits that I or the other family members of my residence have under any and all medical, health, supplemental, worker's compensation, liability, auto or homeowner's insurance policies or plans, or from other third party payers or sources which provide coverage or would otherwise pay for ambulance services. Such payment sources are collectively referred to in this agreement as "insurance". I authorize the payment of all insurance benefits or payments to CareFlite. I understand that CareFlite will, whenever it deems it feasible, file claims for and directly collect the benefits payable from insurance up to the amount of CareFlite's charges for its services. When requested by CareFlite, I agree to complete any forms and take any other reasonable action that may be necessary to collect such amounts. If I or anyone on my behalf receives any insurance or other third party payments for services provided by CareFlite, I will promptly forward those payments to CareFlite at the address shown at the top of this form.

LIMITATIONS and CONDITIONS: Membership benefits extend to CareFlite's critical care, advanced or basic life support helicopter and fixed wing air ambulance services staffed with nurses, paramedics and pilots, Specialty Care Transport (a ground transport staffed similarly to CareFlite's air ambulance services) as well as ground ambulances staffed with quality trained paramedics and EMTs. Member benefits are not applicable to services rendered by any other provider. As a condition of receiving the benefits of membership with respect to any air or ground ambulance transport, members with insurance agree to and must comply with all coverage conditions of their applicable insurance program for such transport. Some insurance programs require the insured person to obtain prior authorization of payment for non-emergency, yet medically necessary air ambulance services. (This requirement typically applies to fixed wing air ambulance and inter-facility ground ambulance only but not to helicopter or 911/EMS emergency services.) Non-insured household family members will automatically receive a 50% membership discount on CareFlite's standard charges for the services rendered. Some plans require certain documentation from the insured within a specified time limit or the plan(s) deny or reduce coverage for ambulance services. In the event the member with insurance forfeits coverage by failing to comply with these types of requirements for a transport that would otherwise be covered by insurance, the member will then forfeit membership benefit for failing to so comply and their membership can be revoked at CareFlite's discretion. Membership is available for sale only in those counties or jurisdictions shown on CareFlite's website www.careflite.org . Ground ambulance benefits are available to all members but only in CareFlite's ground ambulance service areas. The member must hold a membership that is in good standing at the time of service and the transport must originate in CareFlite's deemed service area with CareFlite as the transporting agency. CareFlite reserves the right to deny or revoke any membership for reasonable cause. If membership is revoked then all balances are due in full. CareFlite may terminate the membership program at any time upon notice to the members. If CareFlite terminates the program, members will have any unused, prorated portion of their membership fee returned. To protect member fees, CareFlite maintains a bond with an A rated insurance company. CareFlite's Membership benefits are honored by certain other medical transport programs. Visit www.careflite.org for complete details.

CareFlite is a 501(c)3 not for profit air & ground ambulance service sponsored by:

Baylor Scott & White Health · JPS Health Network · Methodist Health System · Parkland · Texas Health Resources

WWW.CAREFLITE.ORG ♥ MEMBERSHIP (877) DFW CARE

City of Rio Vista

Opt Out Form
201 S. Highway 174
Rio Vista, TX 76093

Name: _____

Address: _____

City/State/Zip Code: _____

Utility Account # _____

The undersigned hereby notifies the City of Rio Vista that he/she is the authorized account holder of the above account and that he/she exercises the right to opt out of the $1 per month fee for the Caring Heart Membership. The undersigned acknowledges that the fee will be removed at the conclusion of the next billing cycle. As a result of opting out, I acknowledge that no one in my household will receive the benefits of the Caring Heart Membership Program which protects families against out of pocket costs for CareFlite's air and ground ambulance service.

_____ _____

Signature Date Signed

_____ _____

City of Rio Vista Employee Witnessing Signature Above Date Signed

For Water Department Use Only:

☐ $1 CareFlite Membership Fee removed from account shown above on _____ by _____.