City of Arcadia
Paramedic Membership Program
Resident Application

1) Name of Account Holder: _____ **2) Contact Number:** _____

3) Home Address: _____

4) Billing Address (If Different): _____

5) Number of Permanent Household Members: _____

6) Please provide the names of all permanent household members you would like to enroll for your residence. List the names on the back of this form.

7) Please check the preferred billing option, and submit payment with application:

☐ **$51** billed annually for 12 months of coverage*

☐ **$27** for 12 months of coverage (retirement-facility residents *only*)

**(Qualifying low-income applicants: a reduced annual amount is available if approved by the City of Arcadia. To be eligible, a low-income form, with supporting financial documentation, must accompany this application. If approved, a refund will be issued/mailed to the applicant. For this initial application, the fee for regular membership must be paid).*

Paramedic Membership Program Agreement:
(Please **read** carefully and **sign.**)

I understand the membership fee provides protection for me and all enrolled permanent members of my household from Arcadia's paramedic and ambulance fees. I agree to provide a list of the names of the enrolled members. I understand that I must be a resident of the City of Arcadia to enroll in this program and that households located outside of the City's boundaries are ineligible. I understand that this fee protection only applies to emergency medical treatment and/or ambulance transportation services rendered within the City of Arcadia boundaries by the Arcadia Fire Department or other providers authorized by the Arcadia Fire Department. I understand that membership fees are non-refundable. I also understand the Arcadia Fire Department reserves the right to bill any insurance that I or any household member may have if emergency medical service is rendered. Any payment received by me or any household member or the City of Arcadia will be accepted as payment for emergency medical services performed. I also agree to immediately forward any payment received by me or any household member to the City of Arcadia. I further authorize the release of emergency medical/insurance information for the purpose of emergency medical service billing only. I understand membership begins upon receipt of payment by the Fire Department. I understand this membership is non-transferable and any violations of the terms of this agreement and/or other abuses of membership as deemed by the Fire Chief could result in the cancellation of my membership.

Authorized Member's Signature: _____ **Date:** _____

Please submit 1) this application *(signed and dated by the applicant);* and **2) a check payment** payable to the "City of Arcadia" for one year of membership to the following:

Attn: Paramedic Membership Program
Arcadia Fire Department
710 S. Santa Anita Avenue
Arcadia, CA 91006

For questions about the Paramedic Membership Program, please call (626) 574-5111 or (626) 574-5126; or email us at PMP@ArcadiaCA.gov. To request a low- income discount form, please contact the Utility Billing/Public Works Services at (626) 254-2720 or email them at wb@ArcadiaCA.gov.