



Indian Valley Community Services District

Providing services for our community health, well-being, and prosperity

IVCSD PAYMENT PLAN REQUEST FORM

Customer Information

First and Last Name: _____

Service Address: _____

Mailing Address: _____

Phone Number: _____

Email Address: _____

IVCSD Account Number: _____

Total Amount Owed: \$ _____

Request Type: ☐ Deferred ☐ Reduced ☐ Alternative Payment Schedule

Down Payment Amount (if any): \$ _____

Desired Monthly Payment: \$ _____

Preferred Payment Due Date: _____

Proposed Start Date: _____

Request Details

I am requesting to establish a deferred, reduced, or alternative payment schedule due to financial hardship or inability to pay the full balance at this time.

Reason for Request (brief explanation):



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Default and Collection Remedies

1. Should Customer default on installment payments or materially breach any provisions of this Agreement, the District may, at its option, immediately terminate utility service by providing written notice to Customer. Customer waives all other notification procedures and processes.

2. In the event of default, all delinquent charges shall be immediately due and collectible under this Agreement.

3. In addition, in the event of default, the District retains all remedies provided under Government Code Section 61115, including but not limited to: (1) recording a lien against the property and any other real property owned by Customer in Plumas County for the total unpaid balance; and (2) requesting the County Auditor to place the delinquent charges on the Property Tax Rolls for collection via property tax procedures. The District reserves the right to exercise any and all remedies individually or collectively.

Agreement

I understand that submission of this form does not guarantee approval. I agree to comply with the terms of any approved payment plan and to make payments on time. I certify that the above information is true and accurate to the best of my knowledge. I understand that failure to comply with the agreed payment plan may result in service discontinuation.

Signature: _____

Printed Name: _____

Date: _____

For Office Use Only

Approved / Denied: _____

Approved Payment Amount: \$ _____

Approval Date: _____

Authorized Signature: _____