CITY OF STOCKTON

Citation Processing Center

PO Box 10479, Newport Beach, CA 92658-0479

REQUEST FOR PAYMENT PLAN

Name: ________________________________ **DL#:** ___________________________________

License Plate: __________________________ **Citation(s) #:** ____________________________

Address: ________________________________ **Phone & Email:** ___________________________________

Enrollment Conditions:

- Only **one** Payment Plan or fine amount in 12 months.
- Citations must be enrolled within 60 days of issuance or 10 days after hearing determination, whichever is later.
- Citation late penalties are removed at time of enrollment. Late penalties are reinstated if plan is not completed.
- Enrollment fee is non-refundable.

[ ] *Standard Payment Plan - $25 due at sign up*

AMOUNT OWED	TIMELINE FOR COMPLETION	MINIMUM MONTHLY PAYMENT	CHECK ONE CATEGORY
$90 - $400	16 months	$25	
$401 - Above	18 months	$56	

No proof of income is required to get enrolled in the Standard Payment Plan. Choose your standard payment plan by calling (800) 989-2058.

[ ] *Low Income/Indigent Payment Plan - $5 due at sign up*

AMOUNT OWED	TIMELINE FOR COMPLETION	MINIMUM MONTHLY PAYMENT	CHECK ONE CATEGORY
$50 - $150	6 months	$25	
$151 - $400	18 months	$25	
$401 -$Above	18 months	$56	

Low Income/Indigent Payment Plan terms are available to those who qualify. Proof of indigent status must be provided. Please review plan terms and conditions. Choose your plan, sign at the bottom and mail it to Citation Processing Center or submit it online along with supporting documents.

2018 POVERTY GUIDELINES https://www.huduser.gov/portal/datasets/il/il2018/2018summary.odn

Number of persons in family/household:	1	2	3	4	5	6	7	8
Annual Income Limit:	$22,300	$25,500	$28,700	$31,850	$34,400	$36,950	$39,500	$42,050

For families/households with more than 8 persons, add $2,550 for each additional person.

Indigent must provide one of the following i.e. either (A), (B), or (C):

(A) Proof of income. Please provide your 3 most recent pay stubs.

1. My monthly income amount is $ ____________
2. Number of people residing in the household: ____________

(B) Must provide Verification of Benefits Form for Public Assistance, or Award Letter for Social Security. Please check the boxes that apply.

[ ] Employment
[ ] In-Home Supportive Services (IHSS)
[ ] Food Stamps
[ ] General Relief (GR), County Relief or
[ ] General Assistance (GA)
[ ] Supplemental Security Income
[ ] Medi-Cal
[ ] California Work Opportunity(Cal Works)

(C) If a person has no Income or does not receive public assistance, a copy of their annual earnings from the Social Security Department is required.

I certify that all statements are true and correct. Any false or incomplete information may subject me to forfeit my rights to a payment plan.

Signature: ___________________________________ **Date:** _________________________

Please return this form along with your supporting documents to: Citation Processing Center, PO Box 10479, Newport Beach, CA 92658-0479 or submit online at www.CitationProcessingCenter.com