**TMF Assessment Review Form for**

**Change of Ownership or New Water System**

|  |  |
| --- | --- |
| Water System Name: | SystemNumber: CA\_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ |
| Assessment Type: [ ]  Change of Ownership [ ]  New Water System  |
| District: | TMF Assessment Date: |
| Evaluation Performed By: | Staff Evaluation Date: |

Has the water system demonstrated capacity in the following elements per the TMF Assessment Form?

**Mandatory TMF Elements**

1. **Consolidation Feasibility:** [ ]  Yes [ ]  No comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.  **Ownership**: [ ]  Yes [ ]  No comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. **Water Rights:** [ ]  Yes [ ]  No comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. **Budget/CIP** [ ]  Yes [ ]  No comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. **Budget Control:** [ ]  Yes [ ]  Nocomments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. **System Description:** [ ]  Yes [ ]  No comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. **Certified Operators:** [ ]  Yes [ ]  Nocomments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. **Source Capacity**: [ ]  Yes [ ]  No comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9. **Operations Plan:** [ ]  Yes [ ]  No comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

10. **Organization:** [ ]  Yes [ ]  Nocomments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

11. **Emergency Response Plan**: [ ]  Yes [ ]  No comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Necessary TMF Elements**

12. **Training:** [ ]  Yes [ ]  No comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

13. **Policies**: [ ]  Yes [ ]  No comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

All “Necessary” TMF Elements that have not been satisfied:

[ ]  There will be a permit condition to be completed within \_\_\_\_\_ months of the TMF assessment date.

SWRCB or LPA Staff Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature & Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_