

**TOWN OF
NORTH PROVIDENCE**

Thomas W. Kane
TAX ASSESSOR & COLLECTOR



**STATE OF
RHODE ISLAND**

Charles Lombardi
MAYOR

Account # _____

Application for Tax Exemption
Pursuant to Chapter III Public Laws of 1976

VARIABLE EXEMPTION APPLICATION FOR 2019

****THE INCOME OF A HUSBAND SHALL BE DEEMED TO INCLUDE THE TOTAL INCOME OF HIS WIFE, AND THE INCOME OF A WIFE SHALL BE DEEMED TO INCLUDE THE TOTAL INCOME OF HER HUSBAND*****

Due on or before April 1st

Applicant: _____

Co-Applicant: _____

Phone: _____

Age: ___ DOB: ___/___/___ Lic. # _____

Age: ___ DOB: ___/___/___ Lic. # _____

UNDER 65 MUST HAVE A DOCTOR'S LETTER STATING 100% DISABLED

S.S. # _____

S.S. # _____

Address: _____ Plat _____ Lot _____

Property Owned: Solely () Jointly () Are you a widow? YES () NO () Date spouse deceased ___ / ___ / ___

If owned Jointly with Whom? _____ Date Property was acquired: _____

Do you own property in other City, Town, or State? If so where? _____

COMBINED INCOME CAN NOT EXCEED \$15,000

Applicant: (Income)

Co-Applicant: (Income)

Amount of SSI _____

Amount of SSI _____

(Please state if amount is yearly, monthly or annually?)

Employment Status/Amt. Earned _____

Employment Status/Amt. Earned _____

Pension earned (if any) _____

Pension earned (if any) _____

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Rental income (if any) _____

Banking institute: _____

Amt. Of Interest earned as of 12/31 \$ _____

Banking institute: _____

Amt. Of Interest earned as of 12/31 \$ _____

Annuities/Ira's/CD's \$ _____ total

List each name/amt. _____

Rental income (if any) _____

Banking institute: _____

Amt. Of Interest earned as of 12/31 \$ _____

Banking institute: _____

Amt. Of Interest earned as of 12/31 \$ _____

Annuities/Ira's/CD's \$ _____ total

List each _____

Any other Income received. _____

CERTIFIED IRS FORMS MUST BE SUPPLIED!

Total Gross Income Filed: \$ _____

Applicant: (Deductions)

Un reimbursed Medical Expenses
(ex. Co-pays, exam's, Dr. Bills)

Total: _____

Un Reimbursed Prescriptions
(You can obtain this from your Pharmacist)

Total: _____

Health Insurance paid out of pocket:

Total: _____

Name of Company: _____

Any other Income received. _____

CERTIFIED IRS FORMS MUST BE SUPPLIED!

Total Gross Income Filed: \$ _____

Co-Applicant: (Deductions)

Un reimbursed Medical Expenses
(ex. Co-pays, exam's, Dr. Bills)

Total: _____

UN Reimbursed Prescriptions
(You can obtain this from your Pharmacist)

Total: _____

Health Insurance paid out of pocket:

Total: _____

Name of Company: _____

