Account # _____

TOWN OF
NORTH PROVIDENCE

Katelyn DeAngelis
TAX ASSESSOR

STATE OF
RHODE ISLAND

Charles Lombardi
MAYOR

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

VARIABLE EXEMPTION APPLICATION FOR 2024

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)

Amount of SSI _____

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

Employment Status/Amt. Earned_____

Pension earned (if any) _____

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. _____

Any other Income received. _____

CERTIFIED IRS FORMS MUST BE SUPPLIED!

Total Gross Income Filed: $_____

Co-Applicant: (Income)

Amount of SSI _____

Employment Status/Amt. Earned_____

Pension earned (if any) _____

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: $_____

Account # _____

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: _____

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: _____

Any other deductions can be listed below;

This application must be filled out completely to the best of your ability. Anything that may not apply to you please write **N/A** in the space provided, otherwise we may think you forgot to include some information.

COPIES OF ALL ABOVE INFORMATION MUST BE SUPPLIED WITHIN ITS ENTIRETY, UPON SUBMITTING APPLICATION.

All applications must be submitted with a certified copy of U.S. Federal Income Tax Return of the current year. Even if you have to file zero, we must have a **certified copy.**

Applications for **100% disabled person's** must be submitted with a medical report or other proof of disability.

APPLICATION WILL BE DENIED WITHOUT REQUIRED PROOF ATTACHED.

I SWEAR THAT THE FORE GOING INFORMATION IS TRUE, COMPLETE, AND CORRECT.

APPLICANT: _____ **Date:** _____

CO APPLICANT: _____ **Date:** _____

Notary:

Subscribed and sworn to me this _____day of_____20_____
In the (city/town) _____or Rhode Island.

Notary Signature: _____
My Commission Expires on: _____

Office use only **Total income:** _____ **Total Deductions** _____
Amount of Gross Income: _____

Approved _____ **Denied**_____

INCOME BRACKET : $0--$8,000 EXEMPT. AMT. $10,000
$8001-$10,000 EXEMPT AMT. $7,000 <CIRCLE ONE!
$10,001-$15,000 EXEMPT AMT $5,000