NEWINGTON FIRE DEPARTMENT
AMBULANCE SERVICE PROVIDER
8 TURCOTTE MEMORIAL DRIVE
ROWLEY, MA 01969-1706

HARDSHIP APPLICATION

Origin

Destination

Date of Service:
Balance Due:

Invoice Date:
Invoice Number:
Patient Name:

This application is to request to have the above customer's ambulance charges canceled. To apply, complete the questions below, sign and return in the enclosed envelope within 5 days.

If your income, based on family size, is less than those listed below, charges may be reduced or abated. Add an additional $10,760 for each person over 8.

FAMILY SIZE	ANNUAL INCOME
1	$30,120
2	$40,880
3	$51,640
4	$62,400
5	$73,160
6	$83,920
7	$94,680
8	$105,440

Your family size:_____ Total Annual Family Income:_____

Please explain any unusual circumstances:

_____

_____

_____

Signed:_____ Phone#_____ Date:_____
I certify that the above information is correct and will supply documentation if requested.

This application will be forwarded to the NEWINGTON FIRE DEPARTMENT for their review and determination.

REMIT TO:
NEWINGTON FIRE DEPARTMENT
8 TURCOTTE MEMORIAL DRIVE
ROWLEY, MA 01969-1706

Please return this letter and fold so that the address to your left is visible in the return envelope window.