

REQUEST FOR ASSISTANCE WITH MEDICAL EXPENSES

Board of Selectmen
Town Hall
Stoneham, MA 02180

Name: _____ Date of Residence in Stoneham: _____

Phone Number: _____ Date of Birth: _____

Address: _____

Responsible Party:

Name: _____ Relationship: _____ DOB: _____

Address _____ Phone Number: _____

Employment:

Present Employer: _____ Salary (Weekly) _____

Address: _____ Phone Number: _____

Dates of Employment _____ From _____ To _____

Dependents not working:

Name _____ Age _____ Name _____ Age _____

Name _____ Age _____ Name _____ Age _____

Name _____ Age _____ Name _____ Age _____

Income from other sources: Spouse, Dependents, Other

Employer _____ Salary (Wkly) _____

Address _____ Phone# _____

Dates of Employment From _____ To _____

Miscellaneous Income Name, Source, Etc. Amount

Rent _____

Pensions _____

Social Security _____

Veteran's Benefits _____

S.S.I. _____

Workmen's Compensation _____

Unemployment Compensation _____

Other (Identify) _____

Personal Assets Name, Source, Etc. Amount

Checking Accounts _____

Savings Accounts _____

Life Insurance, Cash Surrender Value _____

Securities and Bonds _____

Other Personal Assets _____

Total Personal Assets _____

Capital Assets Date of Purchase Purchase Price

Real Estate _____

Automobile _____

2nd Auto Mobile _____

Capital Assets Cont.	Date of Purchase	Purchase Price
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Itemize Other Assets

Health Insurance	Yes	No
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Name	Policy #	
Name	Policy #	

Current Indebtedness	To Whom	Monthly Pmt	Balance
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Mortgage			
Rent			
Loans Outstanding			
Banks			
Finance Company			

Other (Identify) _____

Charge Accounts (Stores, Mastercard, etc.) _____

Other (Identify) Auto, Life and Home Owners Insurance _____

List medical expenses you are currently having difficulty paying:

<u>Hospital/Doctor</u>	<u>Total Bill</u>	<u>Paid</u>	<u>Balance</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Remarks _____

I hereby certify that the information I have given is correct, true and complete.

Signature _____
 Address _____

Date _____

Attach copies of all invoices (Must be itemized bills).