

**TIOGA FIRE DEPARTMENT/AMBULANCE SERVICE
REQUEST FOR DETERMINATION OF ELIGIBILITY
FOR UNCOMPENSATED SERVICES**

Date of Request: _____

I hereby request Tioga Fire Department/Ambulance Service make a written determination of my eligibility for uncompensated services at Tioga Fire Department/Ambulance Service. I understand the information which I submit concerning my annual income and family size is subject to verification by Tioga Fire Department/Ambulance Service. I also understand that if the information which I submit is determined to be false, such a determination will result in denial of providing services as uncompensated services, and that I will be liable for charges for services provided.

1. Name: _____
First
Middle
Last

Address: _____
Number & Street
City
State
Zip

Telephone Number: _____

2. Occupation: _____ Employer: _____

3. Income: List income for family from:	Total for Last 3 Months	Total for Last 12 Months
Wages.....	_____	_____
Farm or Self Employment.....	_____	_____
Public Assistance.....	_____	_____
Social Security.....	_____	_____
Workers Compensation.....	_____	_____
Strike Benefits.....	_____	_____
Alimony.....	_____	_____
Child Support.....	_____	_____
Military Family Allotments.....	_____	_____
Pensions.....	_____	_____
Income from Dividends, Interest, Rent.....	_____	_____

4. Family Size:

<u>NAME</u>	<u>RELATIONSHIP</u>
_____	_____
_____	_____
_____	_____

5. Type of Service Required: _____

I affirm that the above information is true and correct to the best of my knowledge.

 Signature of person making request _____
Date