

Assessors' Use only
Date Received
Application No.
Parcel Id.

\_\_\_\_\_  
Name of City or Town

**LOW INCOME PERSONS - LOW OR MODERATE INCOME SENIORS**  
**FISCAL YEAR \_\_\_\_\_ APPLICATION FOR COMMUNITY PRESERVATION ACT EXEMPTION**  
**General Laws Chapter 44B**

THIS APPLICATION IS NOT OPEN TO PUBLIC INSPECTION  
 (See General Laws Chapter 44B, § 3 and Chapter 59, § 60)


**Return to: Board of Assessors**

Must be filed with assessors on or before April 1, or  
 3 months after actual (**not** preliminary) tax bills are  
 mailed for fiscal year if later.

**INSTRUCTIONS:** Complete all sections. Please print or type.

**A. IDENTIFICATION.** Complete this section fully.

Name of Applicant _____			
Telephone Number _____	Marital Status _____		
Were you 60 years or older on January 1, _____? Yes <input type="checkbox"/> No <input type="checkbox"/>			
<i>If yes and first year of application, please attach copy of birth certificate.</i>			
Legal residence (domicile) on January 1, _____	No. _____	Street _____	City/Town _____ Zip Code _____
Mailing address (if different) _____	No. _____	Street _____	City/Town _____ Zip Code _____
Location of property: _____	No. of dwelling units: 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> Other _____		
Did you own the property on January 1, _____? Yes <input type="checkbox"/> No <input type="checkbox"/>			
<i>If yes, were you:</i> Sole owner <input type="checkbox"/> Co-owner with spouse only <input type="checkbox"/> Co-owner with others <input type="checkbox"/>			
Was the property subject to a trust as of January 1, _____? Yes <input type="checkbox"/> No <input type="checkbox"/>			
<i>If yes, please attach trust instrument including all schedules.</i>			
Have you been granted any exemption in any other city or town (MA or other) for this fiscal year? Yes <input type="checkbox"/> No <input type="checkbox"/>			
<i>If yes, name of city or town _____ Type of exemption _____</i>			

**B. SIGNATURE.** Sign here to complete the application.

This application has been prepared or examined by me. Under the pains and penalties of perjury, I declare that to the best of my knowledge and belief, the application and all accompanying documents and statements are true, correct and complete.

\_\_\_\_\_  
Signature Date

If signed by agent, attach copy of written authorization to sign on behalf of taxpayer.

**YOU MUST ALSO COMPLETE SCHEDULES C - F ON FOLLOWING PAGES**

FILING THIS APPLICATION DOES NOT STAY THE COLLECTION OF YOUR SURCHARGE.  
 TO AVOID INTEREST AND COLLECTION CHARGES, YOU MUST PAY SURCHARGE AS BILLED BY DUE DATE.  
 IF EXEMPTION IS GRANTED AND SURCHARGE IS PAID IN FULL, REFUND WILL BE MADE.  
 THIS FORM APPROVED BY THE COMMISSIONER OF REVENUE

**C. HOUSEHOLD MEMBERS.** List all members of your household on January 1 and provide requested information. Please list any members who are 18 and older and not full time students last. Documentation may be requested to verify information provided.

	Full Name (First, Middle, Last)	Relationship to Applicant	Age as of 1/1	Occupation or School Grade
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____

*Continue list on attachment, in same format, as necessary.*

**D. HOUSEHOLD OUT OF POCKET MEDICAL EXPENSES DURING PRECEDING CALENDAR YEAR.** List total medical expenses incurred by all household members during calendar year before January 1 that were not paid by or reimbursed by employer, public or private health insurance or other third party. Includes amounts paid in health insurance premiums, co-payments, deductibles and other out of pocket expenses. Documentation may be requested to verify expenses claimed.

TYPE OF EXPENSE	Total Out of Pocket for Preceding Calendar Year
Health insurance premiums	\$ _____
Doctors	\$ _____
Hospitals	\$ _____
Diagnostic tests	\$ _____
Prescription drugs	\$ _____
Medical equipment	\$ _____
Other	\$ _____
<b>TOTAL OUT OF POCKET</b>	\$ _____

**E. HOUSEHOLD GROSS INCOME DURING PRECEDING CALENDAR YEAR.** List income received from all sources for each member of household 18 and older and not full time student during calendar year before January 1. Please list members in same order as shown in Schedule C above. Copies of federal and state income tax returns may be requested to verify income reported for each household member.

TYPE OF INCOME	Applicant Name	Member 1 Name	Member 2 Name	Member 3 Name
Wages, salaries, other compensation	\$	\$	\$	\$
Social Security				
Other pension/retirement benefits				
Interest/dividends				
Rental income				
Net profits from business or profession				
Capital gains				
Alimony				
Child support				
Public assistance				
Unemployment compensation				
Disability compensation				
Other (specify):				
<b>TOTAL GROSS INCOME - MEMBERS</b>	\$	\$	\$	\$
<b>TOTAL GROSS INCOME - HOUSEHOLD</b>				\$

Continue list on attachment, in same format, as necessary.

**F. CO-OWNERS' HOUSEHOLD GROSS INCOME DURING PRECEDING CALENDAR YEAR.**

Does Schedule E above include the gross income of all co-owners of the property as of January 1, \_\_\_\_? Yes  No

If no, a Schedule C, D and E must be attached for each co-owner not included.

DISPOSITION OF APPLICATION (ASSESSORS' USE ONLY)

Age

Ownership

Occupancy

Applicant's Gross Income \$ \_\_\_\_\_

Dependent Deduction \$ \_\_\_\_\_

Medical Deduction \$ \_\_\_\_\_

Applicant's CPA Income \$ \_\_\_\_\_

Co-owner 1 Gross Income  
\$ \_\_\_\_\_

Dependent Deduction \$ \_\_\_\_\_

Medical Deduction \$ \_\_\_\_\_

Co-owner 1 CPA Income \$ \_\_\_\_\_

Co-owner 2 Gross Income  
\$ \_\_\_\_\_

Dependent Deduction \$ \_\_\_\_\_

Medical Deduction \$ \_\_\_\_\_

Co-owner 2 CPA Income \$ \_\_\_\_\_

GRANTED

DENIED

Assessed surcharge \$ \_\_\_\_\_

Exempted surcharge \$ \_\_\_\_\_

Adjusted surcharge \$ \_\_\_\_\_

BOARD OF ASSESSORS

Date voted \_\_\_\_\_

Certificate number \_\_\_\_\_

Date certificate/Notice sent \_\_\_\_\_

Date: