CP-4
Revised 11/2016

The Commonwealth of Massachusetts

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 ☐ No ☐

If yes and first year of application, please attach copy of birth certificate.

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☐ 2☐ 3☐ 4☐ Other ____

Did you own the property on January 1, _____? Yes ☐ No ☐

If yes, were you: Sole owner ☐ Co-owner with spouse only ☐ Co-owner with others ☐

Was the property subject to a trust as of January 1, _____? Yes ☐ No ☐

If yes, please attach trust instrument including all schedules.

Have you been granted any exemption in any other city or town (MA or other) for this fiscal year? Yes☐ No ☐

If yes, name of city or town _____ *Type of exemption* _____

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	$
TOTAL OUT OF POCKET	$

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):				
TOTAL GROSS INCOME - MEMBERS	$	$	$	$
TOTAL GROSS INCOME - HOUSEHOLD				$

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: