

# City of Boston

## LOW INCOME PERSONS - LOW OR MODERATE INCOME SENIORS FISCAL YEAR 2021 APPLICATION FOR COMMUNITY PRESERVATION ACT EXEMPTION General Laws Chapter 44B

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**Return to:** Assessing Department  
Attn: CPA Surcharge  
City Hall, Room 301  
Boston, MA 02201

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

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

Ward \_\_\_\_\_ Parcel \_\_\_\_\_

Name of Applicant \_\_\_\_\_

Telephone Number \_\_\_\_\_ Marital Status \_\_\_\_\_

Were you 60 years or older on January 1, 2020? Yes  No

~~.....ZnYgUbXXZfgimUf cZUdd JWhcbzd YgYUHUW WdncZVlfh WHZWHY'~~

Legal residence (domicile) on January 1, 2020 \_\_\_\_\_  
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, 2020? 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, 2020? 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 -GAPPROVED BY THE COMMISSIONER OF REVENUE

**C. HOUSEHOLD MEMBERS.** List all members of your household on January 1, 2020 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 January 1, 2020	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 CALENDAR YEAR 2019.** List total medical expenses incurred by all household members during calendar year 2019 that were not paid by or reimbursed by employer, public or private health insurance or other third party. Include 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 Calendar Year 2019
Health insurance premiums	\$ _____
Doctors	\$ _____
Hospitals	\$ _____
Diagnostic tests	\$ _____
Prescription drugs	\$ _____
Medical equipment	\$ _____
Other	\$ _____
<b>TOTAL OUT OF POCKET</b>	\$ _____

**E. HOUSEHOLD GROSS INCOME DURING CALENDAR YEAR 2019.** 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 CALENDAR YEAR 2019.**

Does Schedule E above include the gross income of all co-owners of the property as of January 1, 2020? 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: