

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

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Return to: Board of Assessors
 Flynn Building
 278 Old Sudbury Road
 Sudbury, MA 01776

INSTRUCTIONS: Complete all sections. Please print or type.

A. IDENTIFICATION. Complete this section fully.

Name of Applicant _____		Telephone Number _____	
Social Security No. _____		Marital Status _____	
Were you 60 years or older on January 1, _____? Yes No			
<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 2 3 4 Other _____	
Did you own the property on January 1, _____? Yes No			
<i>If yes, were you:</i> Sole owner Co-owner with spouse only Co-owner with others			
Was the property subject to a trust as of January 1, _____? Yes No			
<i>If yes, please attach trust instrument including all schedules.</i>			
Have you been granted any exemption in any other city or town for this fiscal year? Yes No			
<i>If yes, name of city or town</i> _____		<i>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 _____
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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.

	Full Name (First, Middle, Last)	Relationship to Applicant	Date of Birth	Occupation or School Grade	Social Security No. (for verification)
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 before January 1. Please list members in same order as shown in Schedule B 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 B, C 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: