THE COMMONWEALTH OF MASSACHUSETTS

TOWN OF HAMILTON

FISCAL YEAR 2015

ASSESSOR USE ONLY
Parcel I.D. _____ Date Received

LOW INCOME PERSONS-LOW OR MODERATE INCOME SENIORS
FISCAL YEAR 2015 APPLICATION FOR COMMUNITY PRESERVATION ACT EXEMPTION
General Laws Chapter 44B

Application must be filed 3 months after the actual (not preliminary) tax bills are mailed for fiscal year.

1. IDENTIFICATION: (Complete all sections fully)

Name of Applicant_____

Mailing Address_____ Tel. No. _____

Marital Status _____

Were you 60 years or older on January 1, 2014? Yes_____ No _____
If yes and first year of application, please attach a copy of birth certificate.

Legal Residence (Domicile) on January 1, 2014_____

Location of Property _____

Did you own the property on January 1, 2014? Yes ____ No _____

If yes, were you: Sole Owner:_____Co-Owner with Spouse Only_____Co-Owner with Others_____

Was the property held in trust as of January 1, 2014? Yes_____ No_____
(*If yes, attach instrument including all schedules)*

2. INCOME

GROSS INCOME FROM ALL SOURCES IN CALENDAR YEAR **2013** FOR EACH MEMBER OF FAMILY (EXCEPT FULL TIME STUDENTS AND MINOR CHILDREN) AS FOLLOWS: Retirement Benefits (Social Security, Railroad, Federal, Mass, and Political Subdivisions), Other Pensions and Retirement Allowances, Wages, salaries and Other Compensation, Net Profits from Business or Profession, Interest and Dividends, Alimony, Child Support, Rental income, Capital gains, and other.

Total Number of persons residing in Household: ☐

Name: First, Middle, Last	Relationship To applicant	Soc Sec #	Date of Birth	Annual Total Income (All Sources)
	Applicant			
	Spouse			
		TOTAL FAMILY GROSS INCOME:		$

3. DEPENDENT DEDUCTION (Please list all dependents residing in household)

NAMES:	DATE OF BIRTH	FULL TIME STUDENT?
_____	_____	Y N
_____	_____	Y N
_____	_____	Y N
_____	_____	Y N
_____	_____	Y N
_____	_____	Y N

4. MEDICAL EXPENSE DEDUCTION

DEDUCTIONS FOR MEDICAL EXPENSES OF ALL FAMILY MEMBERS IN CALENDAR YEAR **2013**
Note: Do not include amounts that have been reimbursed or paid by insurance

HEALTH INSURANCE PREMIUM	$ _____
HOSPITALS	$ _____
DOCTORS	$ _____
PRESCRIPTION DRUGS	$ _____
MEDICAL EQUIPMENT	$ _____
OTHER	$ _____
TOTAL MEDICAL EXPENSES	$ _____

DID YOU, OR ANY MEMBER OF YOUR FAMILY FILE A FEDERAL INCOME TAX RETURN (S) FOR CALENDAR YEAR **2013**? YES _____NO_____IF YES, A COPY OF PAGE ONE OF THAT RETURN IS REQUIRED FOR ALL FAMILY MEMBERS. (TAX RETURN INFORMATION WILL BE DESTROYED AFTER FINAL DISPOSITION OF THE APPLICATION)

PLEASE NOTE: INFORMATION ON THIS FORM IS NOT SUBJECT TO PUBLIC INSPECTION.
SIGNATURE: (Sign below to complete 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, it and all accompanying documents and statements are true.

_____ _____

Signature(s) Date

** *Filing this application does not stay the collection of your surcharge. To avoid interest and collection charges, you must pay surcharge as billed by the due date. If the exemption is granted and the surcharge is paid in full, then a refund will be made.*