CP-4
Revised 11/2016

The Commonwealth of Massachusetts

# City of Boston

**LOW INCOME PERSONS - LOW OR MODERATE INCOME SENIORS**
**FISCAL YEAR 2026 APPLICATION FOR COMMUNITY PRESERVATION ACT EXEMPTION**
**General Laws Chapter 44B**

**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 1,2025? Yes ☐ No ☐

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

Legal residence (domicile) on January 1, 2025
_____
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, 2025? 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, 2025? 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 IS APPROVED BY THE COMMISSIONER OF REVENUE

**C. HOUSEHOLD MEMBERS.** List all members of your household on January 1, 2025 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, 2025 | 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 2024.** List total medical expenses incurred by ALL household members during calendar year 2024 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 2024 |
|---|---|
| Health insurance premiums | $ |
| Doctors | $ |
| Hospitals | $ |
| Diagnostic tests | $ |
| Prescription drugs | $ |
| Medical equipment | $ |
| Other | $ |
| **TOTAL OUT OF POCKET** | $ |

**E. HOUSEHOLD GROSS INCOME DURING CALENDAR YEAR 2024.** 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 CALENDAR YEAR 2024.**

Does Schedule E above include the gross income of all co-owners of the property as of January 1, 2025? 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: