THE COMMONWEALTH OF MASSACHUSETTS

TOWN OF HAMILTON

**FISCAL YEAR 2026**

| ASSESSOR USE ONLY |
|---|
| Parcel I.D. _____ |
| Date Received |

**LOW INCOME PERSONS-LOW OR MODERATE INCOME SENIORS**
**FISCAL YEAR 2026 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, 2025? Yes_____ No _____
*If yes and first year of application, please attach a copy of birth certificate.*

Legal Residence (Domicile) on January 1, 2025_____

Location of Property _____

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 held in trust as of January 1, 2025? Yes_____ No_____
(*If yes, attach 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_____

## 2. INCOME

GROSS INCOME FROM ALL SOURCES IN CALENDAR YEAR **2024** 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 | 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 **2024**
Note: Do not include amounts that have been reimbursed or paid by insurance

| | |
|---|---|
| Health Insurance Premiums | $ _____ |
| 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 **2024**? 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.*