

TOWN OF LINCOLN

Name of City or Town

Assessors' Use only

Date Received

Application No.

Parcel Id.

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

THIS APPLICATION IS NOT OPEN TO PUBLIC INSPECTION  
(See General Laws Chapter 44B, § 3 and Chapter 59, § 60)

**Return to: Board of Assessors**

Must be filed with assessors on or before December 31, or 3 months after actual (**not** preliminary) tax bills are mailed for fiscal year if later.

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

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

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

Telephone Number \_\_\_\_\_

Marital Status \_\_\_\_\_

Were you 60 years or older on January 1, \_\_\_\_? Yes ☐ No ☐

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

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 ☐

*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, \_\_\_\_? 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 APPROVED BY THE COMMISSIONER OF REVENUE

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**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. Documentation may be requested to verify information provided.

|    | Full Name<br>(First, Middle, Last) | Relationship to<br>Applicant | Age as of 1/1 | Occupation or<br>School Grade |
|----|------------------------------------|------------------------------|---------------|-------------------------------|
| 1. | _____                              | _____                        | _____         | _____                         |
| 2. | _____                              | _____                        | _____         | _____                         |
| 3. | _____                              | _____                        | _____         | _____                         |
| 4. | _____                              | _____                        | _____         | _____                         |
| 5. | _____                              | _____                        | _____         | _____                         |
| 6. | _____                              | _____                        | _____         | _____                         |

*Continue list on attachment, in same format, as necessary.*

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**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<br>Preceding Calendar Year |
|----------------------------|----------------------------------------------------|
| Health insurance premiums  | \$ _____                                           |
| Doctors                    | \$ _____                                           |
| Hospitals                  | \$ _____                                           |
| Diagnostic tests           | \$ _____                                           |
| Prescription drugs         | \$ _____                                           |
| Medical equipment          | \$ _____                                           |
| Other                      | \$ _____                                           |
| <b>TOTAL OUT OF POCKET</b> | \$ _____                                           |

**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 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.

|                                         | Applicant<br>Name | Member 1<br>Name | Member 2<br>Name | Member 3<br>Name |
|-----------------------------------------|-------------------|------------------|------------------|------------------|
| <b>TYPE OF INCOME</b>                   |                   |                  |                  |                  |
| 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 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 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: