

Dear Applicant for Community Preservation Act (CPA) exemption (Cl. 44B):

If you wish to apply, please return this completed and signed application by October 10.

To qualify, you must own and occupy the property as of July 1, 2025 and meet the ownership requirements that are on the application. Please note: If your home is held in a Trust, then you qualify as the homeowner only if you are a Trustee or Co-Trustee and have sufficient beneficial interest in the home.

DOCUMENT REQUIRED WITH YOUR APPLICATION: A copy of your 2024 Income Tax Return.

MAXIMUM INCOME GUIDELINES FOR CPA EXEMPTION in FY2026

If under age 60 on 01/01/2025:		If 60 or over on 01/01/2025:	
2024 Income must have been less than:		2024 Income must have been less than:	
1 person	\$90,104	1 person	\$112,630
2 people	\$102,976	2 people	\$128,720
3 people	\$115,848	3 people	\$144,810
4 people	\$128,720	4 people	\$160,900
5 people	\$139,018	5 people	\$173,772

Everyone must re-apply every year starting on July 1.

Please note: We are sending you this application as a courtesy. It is your responsibility to remember to apply every year.

Thank you, Assessors Dept.- Room 109, City Hall, Medford 781-393-2435

Assessors' Use only	
Date Received	
Application No.	
Parcel Id.	

MEDFORD
Name of City or Town

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 April 1, 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, 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 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. Documentation may be requested to verify information provided.

	Full Name (First, Middle, Last)	Relationship to Applicant	Age as of 1/1	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 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 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 PRECEDING CALENDAR YEAR.

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: