

STATE OF CONNECTICUT - OFFICE OF POLICY AND MANAGEMENT
APPLICATION FOR TAX CREDITS
ELDERLY OR TOTALLY DISABLED HOMEOWNER

FILING PERIOD: FEBRUARY 1st through MAY 15th

2025

OWNER
GRAND LIST

| | | | | |
|--|---------------------------------|--|--|--------------------------------------|
| 1. NAME (Last) | (First) | (Middle Initial) | YOUR BIRTH DATE (mm/dd/yyyy) / / | YOUR SOCIAL SECURITY NO. - - |
| 2. SPOUSE'S NAME (Last) | (First) | (Middle Initial) | SPOUSE'S BIRTH DATE (mm/dd/yyyy) / / | SPOUSE'S SOCIAL SECURITY NO. - - |
| 3. MAILING ADDRESS (No. and Street) | CITY OR TOWN (Don't Abbreviate) | | STATE | ZIP CODE |
| 4. PROPERTY ADDRESS (No. and Street) ONLY IF DIFFERENT FROM 3. ABOVE | CITY OR TOWN | STATE | ZIP CODE | OTHER NAME ON PROPERTY |
| 5. FILING STATUS: <input type="checkbox"/> CIVIL UNION CHECK ONLY ONE: <input type="checkbox"/> MARRIED <input type="checkbox"/> UNMARRIED/WIDOWED | | SURVIVING SPOUSE (AGE 50 TO 65) PROOF REQUIRED | | |
| IF SPOUSE IS A RESIDENT OF A HEALTH CARE OR A NURSING HOME FACILITY IN CT AND ON TITLE XIX <u>CURRENT PROOF REQUIRED</u> | | CHECK HERE: <input type="checkbox"/> | IF APPLICANT IS TOTALLY DISABLED <u>CURRENT PROOF REQUIRED</u> | CHECK HERE: <input type="checkbox"/> |
| 6. DID OR WILL YOU FILE A FEDERAL TAX RETURN FOR THE GRAND LIST YEAR? <input type="checkbox"/> YES (Attach Copy) <input type="checkbox"/> NO | | | | |
| 7. CT QUALIFYING INCOME RECEIVED DURING LAST CALENDAR YEAR: | | | | |
| A. GROSS INCOME - Includes: Federal Gross Income or its equivalent. Such as, but not limited to wages, lottery winnings, pensions, IRA withdrawals, interest, dividends and net rental income (excluding depreciation). A.\$ _____ | | | | |
| B. NON-TAXABLE INTEREST - Example: Interest from Tax Exempt Government Bonds B.\$ _____ | | | | |
| C. SOCIAL SECURITY OR RAILROAD RETIREMENT INCOME - Add Medicare premiums (Attach SSA 1099) C.\$ _____ | | | | |
| D. ANY OTHER INCOME NOT REFLECTED IN THE ABOVE - Examples: Federal Supplemental Security Income, State of Connecticut public assistance payments, Veteran's Disability Pensions, and any other income not listed above. D.\$ _____ | | | | |
| EXPLAIN OTHER: E. TOTAL Add lines 7A through 7D E. \$ _____ | | | | |

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| 8. APPLICANT'S/ AUTHORIZED AGENT'S AFFIDAVIT | The applicant or authorized agent deposes that the above statements are true and complete and claims tax relief under provisions of the Connecticut General Statutes. The property for which tax relief is claimed, is the permanent residence/domicile of the applicant. He/she is not receiving State Elderly tax benefits under section 12-129b or section 12-170d, in any town. The penalty for making a false affidavit is the refund of all credits improperly taken and a fine of not more than \$500.00. Your signature signifies that this affidavit has been read and understood. | | |
| SIGNATURE OF APPLICANT OR AUTHORIZED AGENT X | Date signed (mm/dd/yyyy) _____/_____/_____ | APPLICANT'S OR AGENT'S PHONE NO. () | AGENT'S RELATIONSHIP |

STOP! DO NOT WRITE BELOW THIS LINE - FOR ASSESSOR'S USE ONLY

| | | |
|---|--|---|
| 9. Date Application Received: _____/_____/_____ | 10. Total percentage of property (in fee or in life use) owned by this applicant _____ % | 14. Allowable Table Percentage: _____ % |
| PROPERTY'S GROSS ASMT: \$ _____ | | 15. Credit Maximum: a. Line 13 or **13a X Line 14 \$ _____ b. TableCeiling X Line 10 \$ _____ |
| APPLICANT'S GROSS ASMT: \$ - _____ Subtract Exemptions for: .Blind - _____ Disabled - _____ Veteran's - _____ LocalOptions - _____ Add'l Vets - _____ | | 16.a. Lesser of Line 15a or 15b \$ _____ b. Minimum Grant \$ _____ |
| 11. Net Assessment (based on APPLICANT'S GROSS ASMT. minus total exemptions) (MUST agree with the continuation sheet) \$ _____ | | 17. CREDIT AMOUNT Greater of 16a or 16b \$ _____ |
| 12. Mill Rate: _____ | 13. Amount of Property Tax: or **13a. Amount of Frozen Tax: \$ _____ | ** NOTE: If local option freeze program is offered by municipality you must enter frozen tax amount in Box 13a and Box 15a |

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| ASSESSOR'S AFFIDAVIT | - I am satisfied that the above named applicant meets all the necessary statutory requirements | |
| | - This claim is disallowed for the following reason: _____ {Per Connecticut General Statutes Section 12-170cc an applicant has the right to appeal the Assessor's decision to the Secretary of OPM, in writing, within 30 business days from the date of notice given by the Assessor} | |

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| SIGNATURE OF ASSESSOR OR MEMBER OF ASSESSOR'S STAFF | Date signed (mm/dd/yyyy) _____/_____/_____ |
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