M-35H Rev. 12/2013

STATE OF CONNECTICUT - OFFICE OF POLICY AND MANAGEMENT

2015 GRAND LIST OWNER
-00 (00)

APPLICATION FOR TAX CREDITS
ELDERLY AND TOTALLY DISABLED HOMEOWNER

IMPORTANT: Read instructions available at Assessor's office
FILING PERIOD: FEBRUARY 1st through MAY 15th

1. NAME (Last) (First) (Middle Initial) _____ | YOUR BIRTH DATE (Mo, Day, Yr) ____/____/____ | YOUR SOC. SEC. # ____-____-____

2. SPOUSE'S NAME (Last) (First) (Middle Initial) _____ | SPOUSE'S BIRTH DATE (Mo, Day, Yr) ____/____/____ | SPOUSE'S SOC. SEC. # ____-____-____

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 (Don't Abbreviate) STATE ZIP CODE | OTHER NAME ON PROPERTY

5. FILING STATUS - CHECK ONLY ONE:
___ Civil Union ___ Married ___ Unmarried ___ 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
CURRENT PROOF REQUIRED CHECK HERE: ___

IF APPLICANT IS TOTALLY DISABLED
CURRENT PROOF REQUIRED CHECK HERE: ___

6. DID OR WILL YOU FILE A FEDERAL TAX RETURN FOR THE GRAND LIST YEAR? ___ YES (Attach Copy) ___ 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 though 7D E. _____

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 $500.00 or imprisonment for one year, or both. Your signature signifies that this affidavit has been read and understood.

SIGNATURE OF APPLICANT OR AUTHORIZED AGENT	Date signed (Mo, Day, Yr)	APPLICANT'S OR AGENT'S PHONE NO.	AGENT'S RELATIONSHIP
X _____	____/____/____	( ) INCL. AREA CODE	

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

9. Date Application Received: ____/____/____

PROPERTY'S GROSS ASMNT: $_____

10. Total percentage of property (in fee or in life use) owned by this applicant: ____%

APPLICANT'S GROSS ASMT: $_____*

Subtract Exemptions for:

Blind - $_____

Disabled - $_____

Veteran's - $_____

Local Options - $_____

Add'l Vets - $_____

* Based on Percentage of Ownership

11. Net Assessment (based on APPLICANT'S GROSS ASMT. minus total exemptions) (MUST agree with the continuation sheet) 0

14. Allowable Table Percentage: ____%

15. Credit Maximum:
a. Line 13 or **13a X Line 14 $_____
b. Table Ceiling x Line 10 $_____

16. a. Lesser of Line 15a or 15b $_____
b. Minimum Grant $_____

17. CREDIT AMOUNT
Greater of 16a or 16b $_____

12. Mill Rate: 0

13. Amount of Property Tax: $0.00

or **13a. Amount of Frozen Tax: _____

**NOTE: If local freeze program is offered by municipalit you must enter frozen tax amount in Box 13a and Box 15a

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: _____

Please see the instructions at the Assessor's Office for appeal information.

SIGNATURE OF ASSESSOR OR MEMBER OF ASSESSOR'S STAFF
X _____

Date Signed (Mo,Day,Yr) ____/____/____