

## **GUIDE TO LODGING HOUSE LICENSES**

Pursuant to MGL c140 s23, a license must be obtained before operating a Lodging House. Licensure is valid from the date of the license through the following July 31 only. The fee is \$500.00.

To complete the application:

1. Fill in the Application for a Lodging House License. Fill in and sign the REAP Attestation. Fill in and sign the top half of the Certificate of Good Standing. Fill in and sign the State Dept. of Industrial Accidents Workers Compensation Insurance Affidavit.
2. Proceed to each of these five Departments to obtain sign-offs:

- |                              |                                                                                                                            |
|------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| A. Police Department:        | Monday – Friday, 8:30 AM – 4:00 PM<br>220 Washington Street<br>617 625-6600 x7200                                          |
| B. Fire Prevention Bureau:   | Monday – Friday, 8:00 – 10:00 AM, 3:00 – 5:00 PM<br>255 Somerville Avenue (behind the Police Dept.)<br>617 623-1700 x8400  |
| C. Highways, Lights & Lines: | Monday – Friday, 8:00 AM – 4:00 PM<br>Franey Road (adjacent to Trum Field on Broadway)<br>617 625-6600 x5000               |
| D. Building Inspector:       | Monday – Friday, 8:00 AM – 4:00 PM<br>Franey Road (adjacent to Trum Field on Broadway)<br>617 625-6600 x5600               |
| E. Health Inspector:         | Monday – Friday, 8:00 – 10:00 AM, 3:00 – 4:00 PM<br>Franey Road (adjacent to Trum Field on Broadway)<br>617 625-6600 x4331 |

3. Proceed to the Treasury to confirm that all taxes and fees have been paid and obtain a sign-off on the Certificate of Good Standing, as follows:

Treasury	Monday–Wednesday, 8:30 AM – 4:00 PM
93 Highland Avenue (City Hall)	Thursday, 8:30 AM – 7:00 PM
617 625-6600 x3500	Friday, 8:30 AM – 12:00 PM
4. Submit the application and the fee to the City Clerk’s Office, 93 Highland Avenue, 617 625-6600 x4100. The City Clerk will forward it to the Board of Aldermen for consideration. The Board usually meets on the 2<sup>nd</sup> and 4<sup>th</sup> Thursday of the month. Following Board approval, the Mayor has up to ten days to sign off on the application, before the license can be issued.



Number of residents at this lodging house: \_\_\_\_\_

**ACKNOWLEDGEMENT**

I hereby state that all information provided on this application is true and accurate, and I understand that any information that is found to be false or misleading may result in the forfeiture of this license. This license will be subject to all of the terms, conditions, and limitations set forth in the Somerville Code of Ordinances, any applicable State and Federal laws, and any conditions prescribed by the City of Somerville.

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Phone: \_\_\_\_\_

*Obtain the signatures below before submitting this form to the City Clerk for consideration by the Board of Aldermen.*

__Approved __Denied Date _____ _____ Police Chief or Designee	__Approved __Denied Date _____ _____ Chief Fire Engineer or Designee
__Approved __Denied Date _____ _____ Highways, Lights & Lines Sup't or Designee	__Approved __Denied Date _____ _____ Building Inspector or Designee
__Approved __Denied Date _____ _____ Health Inspector or Designee	

**MASSACHUSETTS DEPARTMENT OF REVENUE  
REVENUE ENFORCEMENT AND PROTECTION (REAP)  
ATTESTATION**

I certify under the penalties of perjury that I, to my best knowledge and belief, have filed all State tax returns and paid all State taxes required under law.

---

\*Signature of Individual or Corporate Name (Mandatory)

---

By: Corporate Officer (Mandatory, if a corporation)

---

\*\*Social Security Number (Voluntary) or Federal Identification Number (Mandatory, if a corporation)

\* This license will not be issued unless this certification clause is signed by the applicant.

\*\* Your Social Security Number will be furnished to the Massachusetts Department of Revenue to determine whether you have met tax filing or tax payment obligations. Licensees who fail to correct their non-filing or delinquency will be subject to license suspension or revocation. This request is made under the authority of Mass. G.L. c. 62C s. 49A.



City of Somerville, Massachusetts  
Finance Department, Treasury Division

**WARNING: TREASURY NEEDS FIVE BUSINESS DAYS TO PROCESS THIS FORM.**

**CERTIFICATE OF GOOD STANDING**

Exact name of taxpayer/applicant's business: \_\_\_\_\_

Address of taxpayer/applicant's business in Somerville: \_\_\_\_\_

Address of taxpayer/applicant's home in Somerville: \_\_\_\_\_

Taxpayer/applicant's phone: day: \_\_\_\_\_ evening: \_\_\_\_\_

I, (print name) \_\_\_\_\_, the undersigned Taxpayer, do hereby certify that all the information contained herein is true and correct and all taxes and fees due the City have been paid or that the Taxpayer has entered into an agreement to pay all taxes and fees and is current on said agreement.

**SIGNED UNDER THE PAINS AND PENALTIES OF PERJURY**, this \_\_\_\_\_ day of

\_\_\_\_\_, 20\_\_\_\_.

(Taxpayer's signature)

**CITY'S ACKNOWLEDGEMENT**

**DATE OF ISSUANCE:** \_\_\_\_\_ **INCLUDES RELEVANT POSTINGS THROUGH:** \_\_\_\_\_

**TAXES AND ACCOUNT NUMBER(S) INCLUDED IN CERTIFICATE:**

Real Estate                       Water/Sewer                       Personal Property                       Other: \_\_\_\_\_

# \_\_\_\_\_                      # \_\_\_\_\_                      # \_\_\_\_\_                      # \_\_\_\_\_

**NOTES:**

**CLERK'S INITIALS:** \_\_\_\_\_

**ORIGINAL STAMP:**

**The Commonwealth of Massachusetts**  
**Department of Industrial Accidents**  
**Office of Investigations**  
**600 Washington Street**  
**Boston, Mass. 02111**

**Workers' Compensation Insurance Affidavit - General Businesses**

**Applicant information:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone #: \_\_\_\_\_

- |                                                                                                                                |                                        |                                                                        |
|--------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|------------------------------------------------------------------------|
| <input type="checkbox"/> I am an employer with _____ employees (full and/or part time).                                        | <b>Business Type:</b>                  | <input type="checkbox"/> Retail                                        |
| <input type="checkbox"/> I am a sole proprietor or partnership and have no employees.                                          |                                        | <input type="checkbox"/> Restaurant/Bar/Eating Establishment           |
| <input type="checkbox"/> We are a corporation that has exercised our right of exemption per c152 s1(4), and have no employees. |                                        | <input type="checkbox"/> Office and/or Sales (real estate, auto, etc.) |
| <input type="checkbox"/> We are a nonprofit organization staffed by volunteers and have no employees.                          |                                        | <input type="checkbox"/> Nonprofit                                     |
|                                                                                                                                |                                        | <input type="checkbox"/> Entertainment                                 |
|                                                                                                                                | <input type="checkbox"/> Manufacturing |                                                                        |
|                                                                                                                                | <input type="checkbox"/> Health Care   |                                                                        |
|                                                                                                                                | <input type="checkbox"/> Other _____   |                                                                        |

**Workers' compensation insurance information (if applicable):**

Insurance Company Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone #: \_\_\_\_\_

Policy #: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

**Applicant certification:**

Failure to secure coverage as required under Section 25A of MGL 152 can lead to the imposition of criminal penalties of a fine up to \$1,500.00 and/or one years' imprisonment as well as civil penalties in the form of a STOP WORK ORDER and a fine of \$100.00 a day against me. I understand that a copy of this statement may be forwarded to the Office of Investigations of the DIA for coverage verification.

I do hereby certify under the pains and penalties of perjury that the information provided above is true and correct.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

*Official use only. Do not write in this area. To be completed by city or town official.*

City or Town: \_\_\_\_\_ Permit/License #: \_\_\_\_\_

- Board of Health
- Building Department
- City/Town Clerk
- Licensing Board
- Selectmen's Office
- Other \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone #: \_\_\_\_\_