PTAX-343-A Physician's Statement for the Homestead Exemption for Persons with Disabilities

Read this first

To qualify for the Homestead Exemption for Persons with Disabilities (HEPD), proof of a disability is required. The acceptable proof of disability is listed on the back of this Form. If you are unable to provide any of these as proof of your disability, you and an Illinois licensed physician must complete Form PTAX-343-A. You are responsible for any physicians' costs.

Step 1: Applicant - Complete the following information

1 ______________________________
Property owner's name

____
Street address of homestead property

______________________ IL __________
City ZIP

(___ ___ ___)___ ___ ___ - ___ ___ ___ ___
Daytime phone

2 Write the assessment year for which you are requesting the HEPD: ___ ___ ___ ___
Year

3 Write the property index number (PIN) of the property for which you are filing this form. Your PIN can be found on your property tax bill or you may obtain it from your Chief County Assessment Officer (**CCAO**). If you are unable to obtain your PIN, write the legal description on Line b.

a PIN __ __ - __ __ - __ __ __ - __ __ __ - __ __ __ __

b Attach a separate sheet if needed.

____

____

Step 2: Physician - Complete the following information

Part A: Patient information - Please print.

The patient must meet the total disability criteria established by the Social Security Administration.
Note: Alcoholism or drug abuse is not included in the Social Security Administration's guidelines as a qualification for disability status.

4 Patient's name: ______________________________

5 Date patient became disabled ___ ___/___ ___/___ ___ ___ ___

6 Can the patient do the same type of work as prior to their disability? Yes ☐ No ☐

6a Was the patient able to work for a living after this date? Yes ☐ No ☐

7 Has the disability lasted or is it expected to continue for 12 months or more? Yes ☐ No ☐

8 Check **all** major body systems, disorders, and diseases of the patients disability:

- ☐ **1.00** Musculoskeletal
- ☐ **2.00** Special Senses and Speech
- ☐ **3.00** Respiratory
- ☐ **4.00** Cardiovascular
- ☐ **5.00** Digestive
- ☐ **6.00** Genitourinary
- ☐ **7.00** Hematological
- ☐ **8.00** Skin
- ☐ **9.00** Endocrine
- ☐ **10.00** Impairments that Affect Multiple Body
- ☐ **11.00** Neurological
- ☐ **12.00** Mental
- ☐ **13.00** Malignant Neoplastic
- ☐ **14.00** Immune

9 What is the nature of the disability: ______________________________

Part B: Physician information

10 Name: ______________________________

11 Your Illinois physician's license number issued by the Illinois Department of Financial and Professional Regulations: 0 3 6 - ___ ___ ___ ___ ___ ___

12 **Sign below:**
I have examined this patient and based on the Social Security Administration's criteria for disability, I state that the information contained in Step 2 is true, correct and complete to the best of my knowledge.

Physician's signature: ______________________________ Date: _____/_____/_____

General Information

What is considered proof of disability?

1 A Class 2 Illinois Person with a Disability Identification Card from the Illinois Secretary of State's Office. Class 2 or Class 2A qualifies, Class 1 or 1A does **not** qualify.

2 Proof of Social Security Administration (SSA) disability benefits which includes an award letter, verification letter or annual Cost of Living Adjustment (COLA) letter (only Form SSA-4926-SM-DI). If you are under the age of 65 receiving Supplemental Security Income (SSI) disability benefits, proof includes a letter indicating SSI payments (SSA-L8151, SSA-L8155, or SSA-L8156).

3 Proof of Veterans Administration disability benefits which includes an award letter or verification letter indicating you are receiving a pension for a non-service connected disability.

4 Proof of Railroad or Civil Service disability benefits which includes an award letter or verification letter of total (100%) disability.

5 If you are unable to provide proof of your disability as listed above, you must submit Form PTAX 343-A, Physician's Statement for the Homestead Exemption for Persons with Disabilities, to your Chief County Assessment Officer (CCAO). Step 2 must be completed by a physician licensed by the state of Illinois. You will be responsible for any costs incurred for your examination by any physician.

When and where must I file this Form PTAX-343-A?

You must file Form PTAX-343- A with your Chief County Assessment Officer (**CCAO**) at the address shown below prior to your county's due date for the Homestead Exemption for Persons with Disabilities (HEPD). Contact your CCAO at the telephone number or address below for assistance.

File or mail your completed Form PTAX-343-A:

____

____
Mailing address

_________________________________ IL ____________
City ZIP

If you have any questions, please call: (____) ______________

Social Security Administration's Listing of Impairments

The Listing of Impairments describes, for each major body system, impairments that are considered severe enough to prevent a person from doing any gainful activity. Most of the listed impairments are permanent or expected to result in death, or a specific statement of duration is made. For all others, the evidence must show that the impairment has lasted or is expected to last for a continuous period of at least 12 months. The criteria in the listing of impairments are applicable to evaluation of claims for disability benefits from the Social Security Administration (SSA). Visit SSA web site at **socialsecurity.gov** for more specific information.

1.00 Musculoskeletal System
2.00 Special Senses and Speech
3.00 Respiratory System
4.00 Cardiovascular System
5.00 Digestive System
6.00 Genitourinary System
7.00 Hematological Disorders
8.00 Skin Disorders
9.00 Endocrine System
10.00 Impairments that Affect Multiple Body Systems
11.00 Neurological
12.00 Mental Disorders
13.00 Malignant Neoplastic Diseases
14.00 Immune System

Official use. Do not write in this space.

Date received: ___ ___/___ ___/___ ___ ___ ___
Month Day Year

DFPR license verified: ___ ___/___ ___/___ ___ ___ ___
Month Day Year

Comments:____

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