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Disabled Persons Homeowner Exemption

Tax Year _____ C/E Number _____

Property Index Number(s) _____

Property Street Address _____

City _____ State _____ Zip _____

Township _____

Owner / Taxpayer _____

Owner's Mailing Address _____

City _____ State _____ Zip _____

Daytime Phone Number _____

Check your type of residence:

O Single-family dwelling O Duplex
O Townhouse O Condominium
O Apartment O Other _____

Is your residence operated as a cooperative? O Yes O No

Is the residence a life care facility under the Life Care Facility Act? O Yes O No

If **"Yes"** to both of the above, is the disabled person liable by contract with the owner(s) for payment of property taxes? O Yes O No

On January 1st, did you occupy this property as your principal residence? O Yes O No

On January 1st, were you the owner of record or did you have a legal or equitable interest or did you have a life care contract with a facility under the Life Care Facilities Act? O Yes O No

If **"No"**, write the date you first occupied this property (if applicable). _____

On January 1st, were you liable for the payment of real estate taxes on this property? O Yes O No

On January 1st, were you a resident of a facility licensed under the Nursing Home Care Act? O Yes O No

If **"Yes"**, was the property occupied by your spouse? O Yes O No

Did this property remain unoccupied? O Yes O No

Check the type of documentation you are attaching as proof that you are the owner of record or have a legal or equitable interest in the property.

O Deed O Contract for deed
O Trust Agreement O Life Care contract
O Lease O Other _____

Write the date on which the written document was executed. _____

***Note:** You may attach a separate sheet describing your specific factual situation. You **must provide one of the specified documents** listed on the back of this form as proof of your disability. See this section: "What types of documents must be provided with this form as proof of my disability?"*

I state that to the best of my knowledge, the information on this application is true, correct and complete.

Signature of Owner/Lessee or Representative _____ Date _____

PTAX-343-A

Physician's Statement for Disabled Persons' Homestead Exemption

Read this first

To qualify for the Disabled Persons' Homestead Exemption (DPHE), 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 DPHE: ___ ___ ___ ___
Year

3 Write the property index number (PIN) of the property for which you are f ling this form. Your PIN can be found on your property tax bill or you may obtain it from your Cook County Assessor's Off cer (**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	☐	**8.00**	Skin
☐	**2.00**	Special Senses and Speech	☐	**9.00**	Endocrine
☐	**3.00**	Respiratory	☐	**10.00**	Impairments that Affect Multiple Body
☐	**4.00**	Cardiovascular	☐	**11.00**	Neurological
☐	**5.00**	Digestive	☐	**12.00**	Mental
☐	**6.00**	Genitourinary	☐	**13.00**	Malignant Neoplastic
☐	**7.00**	Hematological	☐	**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: ____/____/____