

Cynthia L. Froggatt Plumas County Assessor 1 Crescent Street Quincy, CA 95971 Phone: 530-283-6380 Fax: (530) 283-6195 CindieFroggatt@countyofplumas.com

## **CERTIFICATE OF DISABILITY**

The claimant listed below has applied to transfer their property tax base to a replacement property as provided by section 69.5 of the Revenue and Taxation Code. In order to qualify for this one-time tax benefit, a licensed physician or surgeon of appropriate specialty must certify the disability of the claimant, or claimant's spouse, is both severe and permanent. The definition for a severely and permanently disabled person is, ". . . any person who has a physical disability or impairment, whether from birth or reason of accident or disease, including, but not limited to, any disability or impairment which affects sight, speech, hearing or use of any limbs and which results in a functional limitation as to employment or substantially limits one or more major life activities of that person, and which has been diagnosed as permanently affecting the person's ability to function." (Revenue and Taxation Code section 74.3)

\_\_\_\_\_ Date of disability: \_\_\_\_

## I. TO BE COMPLETED BY A PHYSICIAN (please print)

Patient's Name: \_

Description of patient's disability:

Identify: (1) the specific reasons why the disability necessitates a move to the replacement dwelling and (2) the disability-related requirements, including any locational requirements, of a replacement dwelling:

I am a licensed physician su

surgeon. My specialty is:

	CERTIFICATION		
I certify that in my medical opinion the	e above named patient does qualify as a disabled pe	erson according to the definition above.	
PHYSICIAN'S SIGNATURE	DATE		
PHYSICIAN'S NAME (print or type)	DAYTIME PHONE NUMBER		
II. TO BE COMPLETED BY CLAIMANT, CL	AIMANT'S SPOUSE OR LEGAL GUARDIAN (plea	se print)	
CLAIMANT'S NAME	SPOUSE'S NAME		
ROPERTY ADDRESS		ASSESSOR'S PARCEL NUMBER	
	CERTIFICATE OF DISABILITY (check A or B)		
A: 1. The claimant or spouse must des identified in Part I (Part I must be	scribe in their own words how the replacement dwelli e completed by a physician):	ing meets the disability-related requirements	
	AND		

2. I certify (or declare) under penalty of perjury under the laws of the State of California that the primary purpose of the move to the replacement dwelling is to satisfy the identified disability-related requirements described in Part I.

OR

] B:	I certify (or declare) under penalty of perjury under the laws of the State of California that the primary purpose of the move to the
	replacement dwelling is to alleviate the financial burdens caused by the disability.

SIGNATURE OF CLAIMANT	DAYTIME PHONE NUMBER	DATE
	( )	
SIGNATURE OF SPOUSE	DAYTIME PHONE NUMBER	DATE
	( )	
E-MAIL ADDRESS		

THIS DOCUMENT IS NOT SUBJECT TO PUBLIC INSPECTION