

## Glenn Zook Solano County Assessor/Recorder

675 Texas Street Ste 2700 Fairfield CA 94533-6338 (707) 784-6210 https://www.solanocounty.com/depts/ar assessor@solanocounty.gov

## **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)

| Code section 74.3)   |                                      |  |
|--|--------------------------------------|--|
| I. TO BE COMPLETED BY A PHYSICIAN (please print)   |                                      |  |
| Patient's Name:  | Date of disability:                  |  |
| Description of patient's disability:   |                                      |  |
| Description of patient's disability.   |                                      |  |
| Identify: (1) the specific reasons why the disability necessitates a rincluding any locational requirements, of a replacement dwelling:  | move to the replacement dwelling an  | nd (2) the disability-related requirements |
| I am a licensed physician surgeon. My specialty is:  | RTIFICATION                          |  |
| I certify that in my medical opinion the above named patien  | nt does qualify as a disabled person | according to the definition above.         |
| PHYSICIAN'S SIGNATURE  |                                      | DATE                                       |
| PHYSICIAN'S NAME (print or type)   |                                      | DAYTIME PHONE NUMBER                       |
| II. TO BE COMPLETED BY CLAIMANT, CLAIMANT'S SPOUSE   | OR LEGAL GUARDIAN (please pri        | nt)  |
| CLAIMANT'S NAME  | SPOUSE'S NAME                        |  |
| PROPERTY ADDRESS   |                                      | ASSESSOR'S PARCEL NUMBER                   |
| CERTIFICATE OF   | DISABILITY (check A or B)            |  |
| A: 1. The claimant or spouse must describe in their own wor identified in Part I (Part I must be completed by a physical state of the complete |                                      | eets the disability-related requirements   |
|  |                                      |  |
| <ol><li>I certify (or declare) under penalty of perjury under th<br/>replacement dwelling is to satisfy the identified disabili</li></ol>  |                                      |  |
| ☐ B: I certify (or declare) under penalty of perjury under the replacement dwelling is to alleviate the financial burdens  | laws of the State of California that | the primary purpose of the move to the     |
| 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

