

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
- _____ ^{IL} _____
Street address of homestead property
- 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 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 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 patient's disability:
- | | |
|---|--|
| <input type="checkbox"/> 1.00 Musculoskeletal | <input type="checkbox"/> 8.00 Skin |
| <input type="checkbox"/> 2.00 Special Senses and Speech | <input type="checkbox"/> 9.00 Endocrine |
| <input type="checkbox"/> 3.00 Respiratory | <input type="checkbox"/> 10.00 Impairments that Affect Multiple Body |
| <input type="checkbox"/> 4.00 Cardiovascular | <input type="checkbox"/> 11.00 Neurological |
| <input type="checkbox"/> 5.00 Digestive | <input type="checkbox"/> 12.00 Mental |
| <input type="checkbox"/> 6.00 Genitourinary | <input type="checkbox"/> 13.00 Malignant Neoplastic |
| <input type="checkbox"/> 7.00 Hematological | <input type="checkbox"/> 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: 036 - _____

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

To qualify for the Disabled Persons' Homestead Exemption (DPHE), proof of a disability is required. The acceptable proof of disability is listed below. 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.

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 Disabled Persons' Homestead Exemption (DPHE). Contact your CCAO at the telephone number or address below for assistance.

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

Mercer County, CCAO

100 SE 3rd St
Mailing address

Aledo IL 61231
City ZIP

If you have any questions, please call: (309) 582-7814

What is considered proof of disability?

- 1 A Class 2 Illinois Disabled Person 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.

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 for more specific information.

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

Official use. Do not write in this space.

Date received: ___/___/___
Month Day Year

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

Comments: _____

