Use your mouse or Tab key to move through the fields. Use your mouse or space bar to enable check boxes.

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 physician's 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, Advanced Practice Nurse, Physician Assistant, or Optometrist - 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:

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

9 What is the nature of the disability? _____

Part B: Physician, Advanced Practice Nurse, Physician Assistant, or Optometrist information

10 Name: _____

11 Enter your license number and issuing state:

License number: _____ State: _____

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, Advanced Practice Nurse, Physician Assistant, or Optometrist signature Date

General Information

To qualify for the Homestead Exemption for Persons with Disabilities (HEPD), 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 a licensed physician, advanced practice nurse, physician assistant, or optometrist must complete Form PTAX-343-A. You are responsible for any physicians' costs.

Note: Certification by a licensed Optometrist is limited to disabilities related to visual impairment.

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.

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 to:

Hancock County, CCAO

PO Box 444
Mailing address

Carthage **IL**
City ZIP

If you have any questions, please call: (217)357 -2615

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 the SSA website for more specific information at **ssa.gov**.

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

Reset Print

Official use. Do not write in this space.

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

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

Comments:_____

_____

_____