# 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