EF-62-A-R04-0810-27000804-1 BOE-62-A REV. 04 (08-10)

## **CERTIFICATE OF DISABILITY**

The claimant listed below has applied to transfer his or her 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)

N P S P F

## **Xochitl Marina Camacho Monterey County Assessor**

P. O. Box 570 Salinas, CA 93902-0570 Phone: (831) 755-5035 Fax: (831) 755-5435 assessor@co.monterey.ca.us

Patient's Name:	I. TO BE COMPLETED BY A PHYSICIAN (please print)		
Identify: (1) the specific reasons why the disability necessitates a move to the replacement dwelling and (2) the disability-related requirent including any locational requirements, of a replacement dwelling:    Am a licensed	Patient's Name:	Date of d	lisability:
I am a licensed physician surgeon. My specialty is:  CERTIFICATION  I certify that in my medical opinion the above named patient does qualify as a disabled person according to the definition above.  PHYSICIAN'S SIGNATURE  PHYSICIAN'S NAME (print or type)  DAYTIME PHONE NUMBER  ( )  CLAIMANT'S NAME  PROPERTY ADDRESS  ASSESSOR'S PARCEL NUMBER  CERTIFICATE OF DISABILITY (check A or B)  A: 1. The claimant or spouse must describe in his or her own words how the replacement dwelling meets the disability-related require	Description of patient's disability:		
CERTIFICATION  I certify that in my medical opinion the above named patient does qualify as a disabled person according to the definition above.  PHYSICIAN'S SIGNATURE  PHYSICIAN'S NAME (print or type)  DAYTIME PHONE NUMBER ( )  II. TO BE COMPLETED BY CLAIMANT, CLAIMANT'S SPOUSE OR LEGAL GUARDIAN (please print)  CLAIMANT'S NAME  PROPERTY ADDRESS  ASSESSOR'S PARCEL NUMBER  CERTIFICATE OF DISABILITY (check A or B)  A: 1. The claimant or spouse must describe in his or her own words how the replacement dwelling meets the disability-related require		e to the replacement dwelling an	nd (2) the disability-related requirements,
PHYSICIAN'S NAME (print or type)  DAYTIME PHONE NUMBER  ( )  DAYTIME PHONE NUMBER  ( )  LAIMANT'S NAME  PROPERTY ADDRESS  CERTIFICATE OF DISABILITY (check A or B)  A: 1. The claimant or spouse must describe in his or her own words how the replacement dwelling meets the disability-related require		FICATION	
PHYSICIAN'S NAME (print or type)  II. TO BE COMPLETED BY CLAIMANT, CLAIMANT'S SPOUSE OR LEGAL GUARDIAN (please print)  CLAIMANT'S NAME  PROPERTY ADDRESS  ASSESSOR'S PARCEL NUMBER  CERTIFICATE OF DISABILITY (check A or B)  A: 1. The claimant or spouse must describe in his or her own words how the replacement dwelling meets the disability-related require	I certify that in my medical opinion the above named patient do	es qualify as a disabled person a	according to the definition above.
II. TO BE COMPLETED BY CLAIMANT, CLAIMANT'S SPOUSE OR LEGAL GUARDIAN (please print)  CLAIMANT'S NAME  PROPERTY ADDRESS  ASSESSOR'S PARCEL NUMBER  CERTIFICATE OF DISABILITY (check A or B)  A: 1. The claimant or spouse must describe in his or her own words how the replacement dwelling meets the disability-related require	PHYSICIAN'S SIGNATURE		DATE
CLAIMANT'S NAME  PROPERTY ADDRESS  ASSESSOR'S PARCEL NUMBER  CERTIFICATE OF DISABILITY (check A or B)  A: 1. The claimant or spouse must describe in his or her own words how the replacement dwelling meets the disability-related require	PHYSICIAN'S NAME (print or type)		DAYTIME PHONE NUMBER
PROPERTY ADDRESS  ASSESSOR'S PARCEL NUMBER  CERTIFICATE OF DISABILITY (check A or B)  A: 1. The claimant or spouse must describe in his or her own words how the replacement dwelling meets the disability-related require	II. TO BE COMPLETED BY CLAIMANT, CLAIMANT'S SPOUSE OR	LEGAL GUARDIAN (please prin	nt)
CERTIFICATE OF DISABILITY (check A or B)  A: 1. The claimant or spouse must describe in his or her own words how the replacement dwelling meets the disability-related require	CLAIMANT'S NAME	SPOUSE'S NAME	
A: 1. The claimant or spouse must describe in his or her own words how the replacement dwelling meets the disability-related require	PROPERTY ADDRESS		ASSESSOR'S PARCEL NUMBER
A: 1. The claimant or spouse must describe in his or her own words how the replacement dwelling meets the disability-related require	CERTIFICATE OF DIS	SABILITY (check A or B)	
			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 replacement dwelling is to satisfy the identified disability-related requirements described in Part I.  OR	<ol> <li>I certify (or declare) under penalty of perjury under the law replacement dwelling is to satisfy the identified disability-re</li> </ol>	ws of the State of California that elated requirements described in	
B: I certify (or declare) under penalty of perjury under the laws of the State of California that the primary purpose of the move replacement dwelling is to alleviate the financial burdens caused by the disability.	B: I certify (or declare) under penalty of perjury under the laws	s 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  DATE	<b>&gt;</b>	DAYTIME PHONE NUMBER	DATE

THIS DOCUMENT IS NOT SUBJECT TO PUBLIC INSPECTION

