EF-19-DC-R02-0522-34000119-1 BOE-19-DC (P1) REV. 02 (05-22)



## CHRISTINA WYNN SACRAMENTO COUNTY ASSESSOR

PROPERTY TRANSFER SECTION 3636 American River Drive, Suite 200 Sacramento, CA 95864-5952 Phone (916) 875-0750 FAX (916) 875-0755 https://assessor.saccounty.gov

## **CERTIFICATE OF DISABILITY**

The claimant listed below has applied to transfer their property tax base to a replacement primary residence. In order to qualify for this tax benefit, a licensed physician or surgeon of appropriate specialty must certify that the disability of the claimant is severe and permanent. The definition of a severely and permanently disabled person is, "... any person who has a physical disability or impairment, whether from birth or by reason of accident or disease, that results in a functional limitation as to employment or substantially limits one or more major life activities of that person, and that has been diagnosed as permanently affecting the person's ability to function, including, but not limited to, any disability or impairment that affects sight, speech, hearing, or the use of any limbs." (Revenue and Taxation Code section 74.3)

I. TO BE COMPLETED BY A PHYSICIAN (please print)	
Patient's Name:	Date of disability:
Description of patient's disability:  Identify: (1) the specific reasons why the disability necessitates a mo	ve to the replacement primary residence and (2) the disability-
related requirements, including any locational requirements, of a replace	
I am a licensed physician surgeon. My specialty is:  CERTIFICATION	OF DISABILITY
I certify that in m <mark>y medical opinion</mark> , the abo <mark>ve</mark> -n <mark>am</mark> ed p <mark>ati</mark> ent d <mark>oe</mark>	es q <mark>ua</mark> lify as a disab <mark>led person</mark> ac <mark>cording to th</mark> e d <mark>efi</mark> nition above.
SIGNATURE OF PHYSICIAN OR SURGEON	DATE
PHYSICIAN OR SURGEON'S NAME (print or type)	DAYTIME PHONE NUMBER
II. TO BE COMPLETED BY CLAIMANT, CLAIMANT'S SPOUSE, OR I	LEGAL GUARDIAN (please pri <mark>nt)</mark>
NAME OF CLAIMANT	NAME OF SPOUSE OR LEGAL GUARDIAN
PROPERTY ADDRESS	ASSESSOR'S PARCEL/ID NUMBER
CERTIFICATION OF DISABILITY-REL	ATED REQUIREMENTS (check A or B)
A: 1. The claimant, spouse, or legal guardian must describe requirements identified in Part I (Part I must be completed	how the replacement primary residence meets the disability-related by a physician or surgeon):
AND  2. I certify (or declare) under penalty of perjury under the law replacement primary residence is to satisfy the identified	rs of the State of California that the primary purpose of the move to the
OR  B: I certify (or declare) under penalty of perjury under the laws replacement primary residence is <b>to alleviate the financial bu</b>	of the State of California that the primary purpose of the move to the <b>Indens</b> caused by the disability.
Please explain:	
SIGNATURE OF CLAIMANT, SPOUSE, OR LEGAL GUARDIAN	PRINTED NAME
DAYTIME PHONE NUMBER  ( )	DATE
EMAIL ADDRESS	I

