Form AV-9A
Rev. 7-10

STATE OF NORTH CAROLINA

CERTIFICATION OF DISABILITY

for PROPERTY TAX EXCLUSION (G.S. 105-277.1)

Applicant's Name: ____
Last First MI

Address: ______________________________ **Date of Birth:** ______Mo_____Day______Yr

______________________________ **Social Security Number:** _____-_____-______

Telephone Number: (H)________________(W)________________(C)________________

Social Security Number (SSN) disclosure is mandatory for approval of the Property Tax Exclusion under G.S. 105-277.1 and will be used to establish the identification of the applicant. The SSN may be used for verification of information provided on this application. The authority to require this number is given by 42 U.S.C. Section 405(c)(2)(C)(i). The SSN and all income tax information will be kept confidential. The SSN may also be used to facilitate collection of property taxes if you do not timely and voluntarily pay the taxes. Using the SSN will allow the tax collector to claim payment of an unpaid property tax bill from any State income tax refund that might otherwise be owed to you. Your SSN may be shared with the State for this purpose. In addition, your SSN may be used to garnish wages or attach bank accounts for failure to timely pay taxes.

DO NOT USE THIS FORM TO CERTIFY DISABILITY FOR THE DISABLED VETERAN EXCLUSION (G.S. 105-277.1C). IT IS A DIFFERENT PROGRAM. YOU MUST OBTAIN A VETERAN'S DISABILITY CERTIFICATION DIRECTLY FROM THE APPROPRIATE FEDERAL AGENCY.

This section can only be completed by a physician licensed to practice medicine in North Carolina or by a governmental agency authorized to determine qualification for disability benefits.

Evidence that someone receives disability payments is not evidence of total and permanent disability.

Definition: G.S. 105-277.1(b)(4) Totally and permanently disabled. – A person is totally and permanently disabled if the person has a physical or mental impairment that substantially precludes him or her from obtaining gainful employment and appears reasonably certain to continue without substantial improvement throughout his or her life.

CERTIFICATION OF DISABILITY: I affirm that I am qualified and authorized to make this determination.

Circle: YES NO I certify that the applicant is currently totally and permanently disabled as defined above in G.S. 105-277.1(b)(4).

Circle: YES NO I certify that the applicant was under my care as of January 1 of this year and was totally and permanently disabled on that date.

Signature: ______________________ **Date:** ______________

Print Name: ______________________ **Phone:** ______________

Title: ______________________ **License No:** ______________

Name of Medical Practice or Government Agency: ______________________

Please submit completed certification to your County Tax Assessor. Do not submit to the N. C. Department of Revenue.