Form AV-9A
Rev. 8-08

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 attach wages or garnish 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 do hereby certify that the above named applicant, on the date below, is totally and permanently disabled as defined in G.S. 105-277.1(b)(4) and as quoted above. I affirm that I am qualified and authorized to make this determination.

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.