Dallas Central Appraisal District
2949 N. Stemmons Freeway, Dallas
Direct Mailing Address: PO Box 560328 Dallas, Texas 75356-0328
(214) 631-0910 or **www.dallascad.org**

PHYSICIAN'S STATEMENT FOR DISABLED PERSON HOMESTEAD EXEMPTION

GENERAL INSTRUCTIONS: If you are **not** receiving Social Security benefits as a disabled individual, then this form can be used by your **physician or NP/PA (with prescriptive agreement) to verify that your medical condition meets the definition of "disabled"** as defined by the Social Security Administration. Complete the **"OWNER INFORMATION"** section of this form and have your physician complete the **"VERIFICATION OF DISABILITY"** section. **YOUR PHYSICIAN MUST MAIL THIS COMPLETED FORM TO THE APPRAISAL DISTRICT.** This form will not be accepted if simply attached to your application.

DISABLED means either 1) a person who has a medically determinable physical or mental impairment that prevents the individual from engaging in any substantial gainful activity and is expected to last for at least 12 continuous months or to result in death; or 2) a person 55 or older and blind and cannot engage in their previous work because of their blindness.

DISABLED PERSON EXEMPTION REQUIREMENTS: You must complete the Residence Homestead Exemption Application to apply for the Disabled Person Exemption. Applications can be printed from our website, www.dallascad.org or call 214–631- 0910. This Physician's Statement form may be used as proof of your disability.

OWNER INFORMATION
(To be completed by the Owner)

DCAD Account Number: _____

Name of Disabled Homeowner: _____

Property Address: _____
Street Address **City, State, ZIP Code**

TX Driver's License / TX ID No: _____ **Date of Birth:** _____

Daytime / Cell Phone No.: _____

VERIFICATION OF DISABILITY
(To be completed by the Physician)

My name is _____, and I am a physician currently licensed to practice in the state of Texas.

I have personal knowledge of the type and extent of physical or mental impairment that currently affects _____ and I have treated or examined this person's condition.

The **last date** I personally treated or examined this person's condition was on _____. (date)

I **affirm** that this impairment is one that results from anatomical, physiological, or psychological abnormalities, which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques. My diagnosis of the impairment can be described in layman's terms as follows:

_____

_____

_____

To my knowledge, the **impairment** described above **occurred on or before** _____ (date).

Do you expect the impairment to improve so that the individual can return to work? Yes ☐ No ☐ If **yes**, when do you expect the individual can return to work? _____ (date).

Check the box that applies to the person named above:

☐ The impairment described above prevents the individual from engaging in any substantial gainful activity and has lasted or is expected to last for at least 12 continuous months or to result in death.

☐ The individual is 55 years of age or older, is legally blind and is unable to engage in his or her previous occupation because of blindness.

Physician or NP/PA (with prescriptive agreement) Signature | **Date** | **License Number** | **Phone Number**

Printed Name | **Office Address, City, State, ZIP Code**

PHYSICIAN'S INSTRUCTIONS: Please complete **ALL** of the **"VERIFICATION OF DISABILITY"** section of this form and **MAIL** to the Dallas Central Appraisal District, PO Box 560328, Dallas, Texas 75356-0328.