

Lassen County Assessor  
 107 S. Roop St  
 Susanville CA 96130  
 (530) 251-2680  
 amurchison@co.lassen.ca.us

## 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, or claimant's spouse, is severe. The definition of a severely disabled person is any person having a great degree of impairment or who is greatly limited by a physical, mental, cognitive, or developmental condition.

### 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 move to the replacement primary residence and (2) the disability-related requirements, including any locational requirements, of a replacement primary residence:

I am a licensed ☐ physician ☐ surgeon. My specialty is: \_\_\_\_\_

### CERTIFICATION OF DISABILITY

*I certify that in my medical opinion, the above-named patient does qualify as a disabled person according to the definition 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 LEGAL GUARDIAN (please print)

NAME OF CLAIMANT

NAME OF SPOUSE OR LEGAL GUARDIAN

PROPERTY ADDRESS

ASSESSOR'S PARCEL/ID NUMBER

### CERTIFICATE OF DISABILITY-RELATED REQUIREMENTS (check A or B)

- ☐ A: 1. The claimant, spouse, or legal guardian must describe how the replacement primary residence meets the disability-related requirements identified in Part I (*Part I must be completed by a physician or surgeon*):

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 to the replacement primary residence is **to satisfy the identified disability-related requirements** described in Part I.*

OR

- ☐ B: *I certify (or declare) under penalty of perjury under the laws of the State of California that the primary purpose of the move to the replacement primary residence is **to alleviate the financial burdens** caused by the disability.*

Please explain: \_\_\_\_\_

SIGNATURE OF CLAIMANT, SPOUSE, OR LEGAL GUARDIAN



PRINTED NAME

DAYTIME PHONE NUMBER

( )

DATE

EMAIL ADDRESS

**THIS DOCUMENT IS NOT SUBJECT TO PUBLIC INSPECTION**