Travis Central Appraisal District
8314 Cross Park Drive
Direct Mailing Address: PO Box 149012 Austin, Texas 78714-9012

PHYSICIAN'S STATEMENT
FOR DISABLED PERSON HOMESTEAD EXEMPTION

GENERAL INSTRUCTIONS: If you are receiving Social Security disability benefits please submit a copy of your eligibility letter, payment stub from Social Security, along with your homestead exemption application. If you are disabled and are **not** receiving disability benefits, or are receiving disability benefits from a source other than Social Security benefits under the Federal Old-Age, Survivors, and Disability Insurance, the below Physician's Statement Form may be used to verify that your medical condition meets the definition of "disabled" as defined by the Social Security Administration. The Social Security Administration defines disabled as follows:

> 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 your previous work because of their blindness.

The following documents **MUST** be provided:

- **A copy of the homestead exemption application**
- **A signed copy of the Physician Statement Form**
- **A copy of your most recent federal income tax return**

Homestead Exemption Applications can be printed from our website at www.traviscad.org under the form tab or call (512)834-9138.

To be completed by owner

OWNER INFORMATION

TCAD 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.: _____

To be completed by the Physician

VERIFICATION OF DISABILITY

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)

To my knowledge, the impairment 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's Signature	Date	License Number	Phone Number

Printed Name	Office Address, City, State, ZIP Code