FORM: PT46B

APPLICATION FOR PARAPLEGIC PROPERTY TAX REDUCTION

APPLICATION DUE ANNUALLY ON OR BEFORE **JANUARY 1** (SDCL 10-4-24.11, 10-4-24.12, 10-4-24.13)

PERSONAL INFORMATION

LAST NAME	FIRST NAME		SOCIAL SECURITY #	
MAILING ADDRESS	CITY	STATE	ZIP	COUNTY
EMAIL ADDRESS	PHONE NUMBER	BIRTH DATE		PARCEL NUMBER
Legal description of property for which exemption is requested:				

ELIGIBILITY

A. Are you a paraplegic or an individual with the loss or loss of use of both lower extremities? ( ) YES ( ) NO

B. Is your home specifically designed as a wheelchair home? ( ) YES ( ) NO

C. Did you own and occupy your home during the entire year of 2020? ( ) YES ( ) NO

D. Do you live alone and have a yearly income under $14,671 OR

Do you live in a household whose members' combined income is under $18,731? ( ) YES ( ) NO

INCOME CALCULATION (ATTACH A COPY OF YOUR COMPLETED 2020 FEDERAL TAX INCOME RETURN)

DID YOU FILE A 2020 INCOME TAX RETURN? IF YES, ATTACH A COPY OF YOUR RETURN.		( ) YES ( ) NO	
FEDERAL ADJUSTED GROSS INCOME	$_____	EXCLUDED INTEREST NOT YET LISTED	$_____
WAGES, SALARIES, TIPS, OTHER EMPLOYEE COMPENSATION	$_____	ALIMONY PAYMENTS NOT YET LISTED	$_____
INTEREST	$_____	SUPPORT PAYMENTS	$_____
DIVIDENDS	$_____	CASH PUBLIC ASST. & RELIEF	$_____
SELF-EMPLOYMENT (EXPLAIN)	$_____	CAPITAL GAINS, EXC FROM ADJ. GROSS INCOME	$_____
SOCIAL SECURITY (ATTACH A COPY OF EACH HOUSEHOLD MEMBER SSA-1099)	$_____	WORKERS COMP.	$_____
MEDICARE PREMIUMS	$_____	LOSS OF TIME INSURANCE	$_____
INCOME CALCULATION CONTINUED...			
TITLE 19, 20, OR SSI	$_____	INTEREST & DIVIDEND LEFT TO ACCUM. EXCEPT ON INSURANCE POLICIES	$_____
VETERAN'S BENEFITS	$_____	OTHER INCOME	$_____
RAILROAD RETIREMENT BENEFITS	$_____	**TOTAL INCOME**	$_____
OTHER PENSIONS AND ANNUITIES	$_____	**ATTACH ALL DOCUMENTS OF INCOME**	

I have examined this claim and it is correct to the best of my knowledge.

APPLICANT'S SIGNATURE			DATE
PREPARER'S SIGNATURE			PHONE NUMBER
ADDRESS	CITY	STATE	ZIP CODE

VERIFICATION

TO BE COMPLETED BY MEDICAL DOCTOR

[ ] I hereby certify that the above individual is a paraplegic.

[ ] I hereby certify that the above individual has suffered the loss or loss of use of both lower extremities.

MEDICAL DOCTOR SIGNATURE			DATE
ADDRESS	CITY	STATE	ZIP CODE

TO BE COMPLETED BY COUNTY AUDITOR

A. INCOME	$_____
B. PERCENT REDUCTION DUE	$_____
C. PROPERTY TAXES (2020 payable 2021)	$_____
D. AMOUNT OF REDUCTION (B x C) (APPLIES TO 2021 TAXES PAYABLE 2022)	$_____

I hereby certify this applicant meets all requirements for a property tax reduction in SDCL 10-4-24.11, 10-4-24.12, and 10-4-24.13.

AUDITOR OFFICE SIGNATURE	DATE