**COUNTY OF KAUA'I**
**REAL PROPERTY ASSESSMENT DIVISION**
4444 Rice St., Suite A-454 Līhu'e, HI 96766
P:(808) 241-4224 F:(808) 241-6252
Email: rpassessment@kauai.gov
Website: www.kauaipropertytax.com

PRINT RESET

Parcel ID (Tax Map Key)

| ZONE | SECTION | PLAT | PARCEL | CPR |
|---|---|---|---|---|
| | | | | |

**FILING DEADLINE SEPTEMBER 30TH**

## CLAIM FOR DISABILITY EXEMPTION

☐ BLIND ☐ DEAF ☐ TOTALLY DISABLED

| OWNER/APPLICANT'S NAME | SOCIAL SECURITY NUMBER | DATE OF BIRTH |
|---|---|---|
| | | |

| PROPERTY (PARCEL) ADDRESS | MAILING ADDRESS IF DIFFERENT FROM PROPERTY ADDRESS |
|---|---|
| | |
| CONTACT NUMBER(S) | CONTACT EMAIL ADDRESS |
| | |

**Above Impairment or disability must be certified by a licensed physician or optometrist. (Form N-172) and said certificate filed at the Real Property Assessment Office.**

SIGNATURE _____ PRINT NAME _____ DATE _____

## CLAIM FOR EXEMPTION LESS THAN 80% DISABLED VETERAN

| OWNER/APPLICANTS NAME | SOCIAL SECURITY NUMBER | DATE OF BIRTH |
|---|---|---|
| | | |

| PROPERTY (PARCEL) ADDRESS | MAILING ADDRESS IF DIFFERENT FROM PROPERTY ADDRESS |
|---|---|
| | |

| VETERAN'S CLAIM # | CONTACT NUMBER | CONTACT EMAIL ADDRESS | |
|---|---|---|---|
| | | | |
| SERVICE ENTRY DATE: | SERVICE DISCHARGE DATE: | INJURY DATE: | RE-EVALUATION DATE, IF APPLICABLE: |
| | | | |

DESCRIBE INJURY:

### CERTIFICATION

**I certify the above facts to be true and that I am disabled due to injuries received while on duty with the armed forces of the United States. I understand that I may be required to submit a physician's report to provide proof of disability. I hereby authorize the Real Property Assessment Division to contact the Veterans Administration on my behalf for the limited purpose of verifying total service connected disability. I understand that if I do not authorize the Real Property Assessment Division to contact the Veterans Administration on my behalf, I may be required to obtain the certification of the Veterans Administration myself to support this application.**

**YES** ☐ **NO** ☐ (check one)

SIGNATURE _____ PRINT VETERANS NAME _____ DATE _____

**FOR OFFICIAL USE ONLY**

Effective Assessment Year _____ Approved ☐ Denied ☐

Received By: _____ Date Received (post office cancellation mark): _____

PRINT Clear Form

FORM
**N-172**
(REV. 2018)

STATE OF HAWAII — DEPARTMENT OF TAXATION

# Claim for Tax Exemption by Person with Impaired Sight or Hearing or by Totally Disabled Person and Physician's Certification

**(NOTE: References to "married" and "spouse" are also references to "in a civil union" and "civil union partner," respectively.)**

**If you are submitting Form N-172 in response to either an adjustment letter or a collection notice, please check here ➤** ☐

## Part I Claim for tax exemption

INDIVIDUAL:

Name of Individual

Individual's Social Security No. | Spouse's Social Security No.

Street Address of Individual

City, State & Postal/ZIP Code

who is (check applicable category)

☐ A person who is **blind** as defined in sec. 235-1, HRS,

☐ A person who is **deaf** as defined in sec. 235-1, HRS,

☐ A **person totally disabled** as defined in sec. 235-1, HRS,

CORPORATION, PARTNERSHIP, or LLC:

Name of Corporation, Partnership, or LLC

Federal Employer I.D. No.

Street Address

City, State & Postal/ZIP Code

all of whose shareholders, partners, or members are individuals who are (check all applicable categories)

☐ **Blind** as defined in sec. 235-1, HRS,

☐ **Deaf** as defined in sec. 235-1, HRS,

☐ **Persons totally disabled** as defined in sec. 235-1, HRS,

hereby claims the benefits provided under the General Excise Tax and/or Income Tax Laws. (Check all applicable categories and provide the information requested. See separate instructions for the definitions of blind, deaf, and person totally disabled.)

☐ General Excise Tax (sections 237-17 and 237-24(13), HRS)

(a) General Excise Hawaii Tax I.D. No. **GE** ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___ - ___ ___

(b) Doing Business As (DBA)_____

(c) Business Address_____

(d) Type of Business Activity_____

(e) Individual's Percentage of Ownership:_____; Spouse's percentage:_____

☐ Income Tax (section 235-54, HRS) (for individuals only)

(a) Name on income tax return (if joint, show both names)

_____

**I declare, under the penalties set forth in section 231-36, HRS, that I have examined/understand the detail contents of this claim and to the best of my knowledge and belief, it is true, correct, and complete.**

**IN THE CASE OF A CORPORATION, PARTNERSHIP, OR LLC, THIS FORM MUST BE SIGNED BY AN OFFICER, PARTNER OR MEMBER, OR DULY AUTHORIZED AGENT.**

Taxpayer Signature (individual, corporate officer, partner or member, or duly authorized agent) | Date

Title

**NOTE: DISABILITY OR IMPAIRMENT MUST BE CERTIFIED BY LICENSED PHYSICIANS, OPTOMETRISTS, ETC., ON THE BACK OF THIS FORM.**

Applicant's Name _____ Social Security Number _____

**Part II** Physician's or optometrist's certification. Complete only one section, even if applicant has multiple disabilities. **This form may be rejected if the appropriate section and the certification are not fully completed.** If Section A is completed, sign authorization for release of information located at the bottom of this page.

## SECTION A — EYE EXAMINATION (Must be done by a qualified ophthalmologist or optometrist.)

1. Diagnosis _____
2. Vision 1) without corrective lenses: OD:_____ OS: _____ 2) with corrective lenses: OD:_____ OS:_____
3. Is this applicant's visual acuity 20/200 or worse in the better eye with corrective lenses? ☐ Yes ☐ No
4. Is the widest diameter of the field of vision less than 20 degrees? ☐ Yes ☐ No
5. Date first certifiable as legally "blind" (MM/DD/YYYY) _____
6. Should applicant be re-examined for tax purposes? ☐ Yes ☐ No If "Yes," when?_____

## SECTION B — HEARING EXAMINATION (Must be done by a qualified otolaryngologist; i.e., Board-certified ear, nose & throat specialist, or a licensed audiologist.)

1. Diagnosis _____
2. Hearing loss (500-2000 Hertz) without aid: Right_____ Left _____ (Decibels ASA or ANSI 1969)
3. Is the applicant's average loss in speech frequencies (500-2000 Hertz) in the better ear, 82 Decibels ASA (or 92 Decibels ANSI 1969) or worse? ☐ Yes ☐ No
4. Date first certifiable as legally "deaf"(MM/DD/YYYY)_____
5. Should applicant be re-examined for tax purposes? ☐ Yes ☐ No If "Yes," when?_____

## SECTION C — REPORT ON DISABILITY (Must be done by physicians as described in the definition for "person totally disabled" under section 235-1, Hawaii Revised Statutes.)

1. Diagnosis _____
2. Date individual came under your care _____ Date individual first disabled or unable to work _____
3. Is the individual totally disabled, either physically or mentally? ☐ Yes ☐ No
4. Is the disability permanent? (See "Person totally disabled" under Definitions in separate instructions.)
   ☐ Yes What is the effective date of disability? (MM/DD/YYYY) _____
   ☐ No When should individual be re-examined to determine extent of disability?(MM/DD/YYYY)_____
5. Is the individual able to engage in any substantial gainful business or occupation? (See "Person totally disabled" under Definitions in separate instructions.) ☐ Yes ☐ No
6. Pertinent symptoms or findings that preclude the individual's ability to engage in gainful work.

_____

## CERTIFICATION BY PHYSICIAN, OPTOMETRIST, ETC.

I hereby certify that the above applicant conforms to the State definition of "Blind," "Deaf," or "Totally Disabled." Sign this certification only if the applicant meets the applicable definition.

Date of Certification

Signature of Certifying Professional

Professional License Number

Date License Expires

Print Name of Certifying Professional

State/Other Licensing Authority

Address of Certifying Professional

## AUTHORIZATION FOR RELEASE OF INFORMATION BY BLIND APPLICANT

I hereby authorize the Department of Taxation, State of Hawaii, to release my name, social security number, address, information on my eye condition and certification of my legal blindness as stated on tax Form N-172, to Ho'opono Services for the Blind Branch, Department of Human Services, State of Hawaii. The purposes of sharing this information are to maintain a State register of persons who are legally blind as mandated by section 347-6, Hawaii Revised Statutes, and to apprise me of services available from Ho'opono Services for the Blind.

Print Full Name of Blind Applicant

Date

Address of Blind Applicant

Signature of Blind Applicant or witnessed X. If signed X used, two witnesses must sign

Social Security Number of Blind Applicant

Witness #1 - Signature, If X used.

Witness #2 - Signature, If X used.