Parcel ID (Tax Map Key)

_____
Enter 12-digit Parcel ID

REAL PROPERTY ASSESSMENT DIVISION
DEPARTMENT OF BUDGET
AND FISCAL SERVICES
CITY AND COUNTY OF HONOLULU
Phone: (808) 768-3799
www.realpropertyhonolulu.com

Hansen's Disease (ROH § 8-10.6) and Blind, Deaf, or Totally Disabled (ROH § 8-10.7)
CLAIM FOR EXEMPTION

This exemption is in addition to the home exemption. File a home exemption claim on Form P-3.

PRINT OWNER/APPLICANT'S NAME	HOME PHONE	BUSINESS PHONE

SOCIAL SECURITY NUMBER	EMAIL ADDRESS

SITE ADDRESS	CITY	STATE	ZIP CODE

MAILING ADDRESS (IF DIFFERENT FROM SITE)	CITY	STATE	ZIP CODE

CERTIFICATION

I (we) certify that I own the home in accordance with ROH § 8-10.6 or ROH § 8-10.7, and the foregoing is true and correct to the best of my knowledge. I understand that any misstatement of facts may be grounds for disqualification. I also understand if I cease to qualify for such exemption, I must report to the assessor within 30 days this change if facts or status. Failure to report a change in facts or status will result in disqualification and penalties.

_____ Owner's Signature

_____ Print Owner's Name

_____ Date

Complete the claim form and deliver or mail (post office cancellation mark) the claim form with supporting documentation, on or before **September 30th** preceding the tax year for which you are claiming the exemption to either:

Real Property Assessment Division
842 Bethel Street, Basement
Honolulu, HI 96813
Telephone: (808) 768-3799

Real Property Assessment Division
1000 Uluohia Street #206
Kapolei, HI 96707
Telephone: (808) 768-3169

This claim cannot be filed by facsimile transmission. For a receipted copy, submit with a self addressed stamped envelope

Obtain a copy of Form N-172 or N-857, completed and certified by your physician, verifying sight or hearing impairment, or total disability. **Do not send RPAD the original**.

Submit both this exemption claim Form P-6 and **a copy of Form N-172 or N-857** on or before September 30th preceding the tax year for which you are claiming this exemption.

FOR OFFICIAL USE ONLY

For Tax Year: _____ **N-172 Form Attached:** ☐ **Yes** ☐ **No** ☐ **Approved** ☐ **Disapproved**

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

Building #: _____ **Building Exemption %:** _____ **Building #:** _____ **Building Exemption %:** _____ **Land Exemption %:** _____

INSTRUCTIONS FOR FILING DISABILITY EXEMPTION FORMS

You can file for disability within all counties that you own property. Contact the Real Property Assessment Division for information.

1. File the IMPAIRED SIGHT, HEARING, OR TOTALLY DISABLED exemption form in duplicate.
2. Fill in the parcel ID for your property.
3. Print your name.
4. Print your address, complete with zip code.
5. SIGNATURE from the person claiming the disabled exemption.
6. DEADLINE, on or before SEPTEMBER 30 PRECEDING the tax year for which such exemption is claimed and the exemption will be effective for the next assessment year and tax year.
7. Include a SELF ADDRESSED STAMPED ENVELOPE to have your receipted copy returned to you.

MEDICAL FORM: ORIGINAL AND ONE COPY OF THE FORM TO THE STATE TAX OFFICE, GIVE REAL PROPERTY A PHOTOCOPY.

1. PHYSICIAN'S CERTIFIED REPORT* (form N-172 or N-857) must be COMPLETED AND CERTIFIED BY YOUR PHYSICIAN. Your physician determines whether you qualify for an IMPAIRED SIGHT, HEARING, or TOTALLY DISABLED exemption.

2. DEADLINE for the P-6 (DISABILITY EXEMPTION FORM) and CERTIFIED MEDICAL FORM in on or before SEPTEMBER 30 PRECEDING the tax year for which such exemption is claimed.

3. DISABILITY EXEMPTION can also be used if you file a HAWAII STATE INCOME TAX RETURN, REAL PROPERTY TAX RETURN OR HAVE A GENERAL EXCISE LICENSE.

*Note: The N-172 can be substituted with the N-857 to qualify for RPAD exemption. The State Department of Taxation accepts only the N-172 form for "impaired sight, hearing, or totally disability claims."

Clear Form

FORM
N-172
(REV. 2020)

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.

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:_____

☐ _____

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.