



**APPLICATION FOR EXEMPTION
100% SOCIAL SECURITY DISABILITY**

Rules and Regulations for the 100% Social Security Disability Exemption

Applicant must file **ANNUALLY**, between **January 2nd** and **March 15th**. Forms are available from the Office of the City Assessor, Providence. Tel: 421-5900.

Applicant must own residence for **THREE** years prior to December 31st of last year. Applicant must reside in residence. A "residence" is to be considered: three (3) living units or less. Dwellings containing commercial, retail and/or office space are **NOT** eligible.

All exemptions will terminate upon conveyance of the property, death of the person exempted or the moving of such person from the property. Exemption will terminate upon the termination of disability benefits. Exemption will terminate upon the applicant reaching the age of **sixty-five** (65). Applicant must then apply for the Senior Citizen Exemption.

Section One:

Name of Applicant: _____ DOB: _____ Social Security No.: _____

Name of Spouse: _____ DOB: _____ Social Security No: _____

Residence Address: _____ City: _____ State: _____ Zip: _____

Prior Address: _____ City: _____ State: _____ Zip: _____

Are you registered to vote in Providence (please circle): YES / NO - If NO, what community: _____

Section Two:

Number of Living Units in your Residence: _____

Does your Residence Contain any Office/Retail/Commercial Space (please circle and indicate which one):
YES / NO : _____

THE UNDERSIGNED APPLICANT, DO HEREBY SWEAR OR AFFIRM THAT THE ABOVE INFORMATION IS TRUE, CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF, THAT I HAVE READ AND UNDERSTAND THE INSTRUCTIONS AND REGULATIONS LISTED ABOVE AND HAVE COMPLETED THE REQUIRED "DISCLOSURE" STATEMENT ON **THE REVERSE SIDE**.

SIGNATURE OF APPLICANT

DATE OF APPLICATION

OVER-----

FOR ASSESSOR'S USE ONLY

Plat: _____ Lot: _____ Unit: _____

Account: _____

Posted: _____ Date: _____

TIME STAMP

MUST BE RETURNED BY MARCH 15th

DISCLOSURE STATEMENT

Name of Applicant: _____ Social Security No.: _____

Mailing Address: _____ City: _____ State: _____

Gentlemen – I receive (Please circle one or both):

SSA (Green Check) and/or SSI (Gold Check)

I HEREBY AUTHORIZE THE SOCIAL SECURITY ADMINISTRATION TO DISCLOSE TO THE CITY ASSESSOR, CITY HALL, PROVIDENCE, RHODE ISLAND, INFORMATION ABOUT MY ELIGIBILITY TO DISABILITY BENEFITS UNDER TITLE II (SSA) OR TITLE XVI (SSI) OF THE SOCIAL SECURITY ACT.

I UNDERSTAND THAT INFORMATION OBTAINED WILL BE USED FOR SPECIAL TAX EXEMPTION CREDITS AND **WILL BE KEPT CONFIDENTIAL**.

SIGNATURE OF CLAIMANT

SOCIAL SECURITY VERIFICATION

_____ The above named person is eligible for Social Security benefits based on a disability under Title II or Title XVI of the Social Security Act.

_____ The above named person is **NOT** eligible for Social Security benefits based on a disability.

SSA Representative

Title