

**PT 46B - APPLICATION FOR PARAPLEGIC PROPERTY TAX REDUCTION  
(SDCL 10-4-24.11, 10-4-24.12, 10-4-24.13)**

**(ATTACH – INFORMATION FOR TAX RELIEF PROGRAMS IN SOUTH DAKOTA)**

**Applicant's Name** \_\_\_\_\_

**Applicant's Mailing Address** \_\_\_\_\_  
\_\_\_\_\_

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**Personal Information**

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Last Name	First Name	Social Security Number
Mailing Address	County	Telephone Number
City	State	Zip Code
	month) _____ (day) _____ (year) _____	Birth Date

Parcel Number \_\_\_\_\_

Legal description of property for which exemption is requested:

**REMINDER: Application must be made on an annual basis**

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**Eligibility**

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- |  |     |    |
|--|-----|----|
| 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 wheel chair home?                                     | YES | NO |
| C. Did you own and occupy your home during the entire year of 2016?                              | YES | NO |
| D. Do you live alone and have a yearly income under \$14,671?                                    | YES | NO |
| OR Do you live in a household whose members' combined income is under \$18,731?                  | YES | NO |

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

\_\_\_\_\_  
Claimant's signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Preparer's signature

\_\_\_\_\_  
Address

\_\_\_\_\_  
City

\_\_\_\_\_  
Telephone Number

**REMINDER: Application must be made on an annual basis**

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**Verification**  
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**TO BE COMPLETED BY MEDICAL DOCTOR**  
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\_\_\_\_\_ 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

\_\_\_\_\_ MD

\_\_\_\_\_

\_\_\_\_\_

Address

=====  
**TO BE COMPLETED BY COUNTY AUDITOR**  
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A. Income \$ \_\_\_\_\_

B. Percent Reduction Due \$ \_\_\_\_\_

C. Property Taxes (2016 payable 2017) \$ \_\_\_\_\_

D. Amount of Reduction (B x C) \$ \_\_\_\_\_  
(Applies to 2017 taxes payable 2018)

PT 46B (12/16)

Original to Director of Equalization

Copy to applicant

**INFORMATION FOR TAX RELIEF PROGRAMS IN SOUTH DAKOTA – 2017 APPLICATION**

1. Personal Information

Last Name	First Name	Social Security Number
Mailing Address	County	Telephone
City	State	Zip Code
	(month) _____	(day) _____ (year) _____
		Birth Date

**2. Income Calculation – Attach a copy of your completed 2016 Federal Income Tax Return**

Did you file a 2016 Income Tax Return? (circle one)      YES      NO  
 If yes - - attach a copy of the return

Federal Adjusted Gross Income	\$ _____	Excluded interest not yet listed	\$ _____
Wages, salaries, tips, other employee compensation	\$ _____	Alimony payments not yet listed	\$ _____
Interest	\$ _____		
Dividends	\$ _____	Support Payments	\$ _____
Self-employment (explain)	\$ _____	Cash Public Asst. & Relief	\$ _____
Social Security (attach a copy of Each household member SSA-1099)	\$ _____	Capital Gains exc From adj. gross income	\$ _____
Medicare premiums	\$ _____	Workers Comp	\$ _____
Title 19, 20 or SSI	\$ _____	Loss of time insurance	\$ _____
Veterans benefits	\$ _____	Interest & dividend Left to accum. except on insurance policies	\$ _____
Railroad retirement benefits	\$ _____	Other Income	\$ _____
Other Pensions and annuities	\$ _____	<b>TOTAL INCOME</b>	\$ _____

**(Attach all documents of income)**