



2025-2026 Persons with Disabilities and Limited Incomes Property Tax Exemption Application – NYS RPTL 459-c

(Nassau County does not charge a fee to file this application.)

Any alteration of this application may result in a denial.

Exemption applications for 2025-26 property tax year must be filed with the Nassau County Department of Assessment by January 2, 2025.

Property Address

House Number & Street: _____ Apt. Number: _____
 City: _____ State: _____ Zip Code: _____

Property Identification SECTION _____ BLOCK _____ LOT _____ CA # or BLDG. # _____ TAX UNIT # _____
 For Condos & Co-ops only

Names of ALL Owners (as recorded on Deed/Certificate of Shares)	Marital Status	Social Security Number	Date of Birth

Name of any Non-Owner Spouse	Marital Status	Social Security Number	Date of Birth
Address (if different from property address)			

Telephone Number: Home () _____ Cell () _____

E-Mail Address: _____

Contact info of someone who can assist you:

Name	Relationship	Phone #

Proof of Ownership (Indicate ALL documents that apply and attach with this application. Co-op owners must provide the CERTIFICATE OF SHARES.)

Deed or Certificate of Shares Entire Trust (If property is in a Trust) Other: _____

** If any owner appearing on any proof of ownership or the spouse of any owner is deceased, a Death Certificate must be attached to this application.*

DATE YOU ACQUIRED OWNERSHIP OF PROPERTY: _____

Proof of Age (Indicate documents submitted for ALL owners)

Birth Certificate Driver's License Passport Naturalization Papers Other: _____

Proof of Residency (Indicate documents submitted for ALL owners)

2023 SSA-1099 (Showing Name and Address) NYS Car or Voter Registration 2023 NYS Resident Income Tax Return

a. Do all owners presently reside on the property to be exempted? Yes No

b. Is an owner absent from the residence due to divorce, legal separation, or explanation of abandonment? Yes No

** If you checked "YES," please provide a copy of your Divorce Decree, Separation Agreement or Notarized Abandonment with this application.*

c. Is an owner receiving medical care as an inpatient in a health care facility? Yes (Date admitted): _____ No

** If you checked "YES," you must submit a letter from the facility showing the date of admission and the cost incurred with this application.*

d. Is any portion of the property used for purposes other than residential, such as commercial, or professional offices? Yes No

** If you checked "YES," explain such use and describe the portion that is used.*

List the address(es) of all real estate that you own, either entirely or in part. (Attach Schedule E and Property Tax Bill (s) for each property)

Do children, including those of tenants, reside on the property and attend a public school in Grades Pre-K to 12?

Yes No ** If you checked "YES," you must obtain a letter from the school verifying the student's enrollment.*

Proof of Disability (Notice of Award letter must be included with this application)

Social Security Administration for entitlement to Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI)

Railroad Retirement Board for entitlement to Railroad Retirement Disability benefits

Certificate from NYS Commission for the Blind and Visually Handicapped stating that applicant is legally blind

United States Postal Service verifying entitlement to a disability pension, and/or VA Disability Pension

If disability was approved by the State of New York Compensation Board, a NOTICE OF DECISION by the Board must be submitted.

Please provide:

Worker's Compensation Case # _____ Date of Disability: _____
 Name of Carrier & Carrier's Case # _____ List of Continuing Payments: _____

STATEMENT OF INCOME

COPIES of your entire **2023** Federal Form 1040, and New York State Income Tax Returns Form IT-201 (with schedules) must be attached to this application. Social Security 1099 & Schedule 1 must be included, if applicable.

Even if you do not file a Federal Income Tax Return or are attaching a copy of a self-prepared return, you may be required to submit an IRS printout of your **Wage and Income Transcript** to verify all taxable and non-taxable income. Call the IRS for an appointment at 1-844-545-5640. If document does not say "Wage & Income Transcript", it is not the correct transcript.

IMPORTANT: You must attach documentation for any amounts entered in this section with the application

SOURCES OF 2023 INCOME FROM ALL OWNERS & OWNER'S SPOUSE	AMOUNT
Salary or Wages <i>(W-2's including Self-Employment)</i>	
Taxable & Non-Taxable Interest/Dividends <i>(All 1099-INT, 1099-DIV and Year-End Statements)</i>	
Unemployment compensation	
Disability/Worker's Compensation/Unemployment <i>(1099-G or Award Letter)</i>	
IRA Total Distribution(s) <i>(1099-R)</i>	
Pensions & Annuities other than IRAs <i>(1099-R statements and include taxable & non-taxable pensions)</i>	
Gross Social Security <i>(Complete copy of SSA-1099 showing name and address)</i>	
VA Disability Pension(s) or Surviving Spouse Disability Pension <i>(Award Letter)</i>	
TOTAL OF ALL INCOME	\$

Nassau County currently allows a deduction for **UN-REIMBURSED** medical and prescription drug expenses.

ALL SUPPORTING DOCUMENTS, AS LISTED BELOW, MUST BE ATTACHED OR THE AMOUNTS ENTERED BELOW WILL NOT BE DEDUCTED. ALL DOCUMENTS MUST SHOW FACILITY NAME, PATIENT NAME AND SHOW PAYMENT RECEIVED BY THAT OFFICE.

CANCELLED CHECKS, RANDOM PHARMACY RECEIPTS, BANK & CREDIT CARD STATEMENTS & INSURANCE EXPLANATION OF BENEFITS WILL NOT BE ACCEPTED AS PROOF OF UN-REIMBURSED EXPENSES.

PLEASE CHECK BOX AND ATTACH COPIES OF ANY PAYMENTS MADE IN 2023	AMOUNT
<input type="checkbox"/> Printout or Statement from the Doctor's/Dentist's office of ALL Payments and Co-Payments	
<input type="checkbox"/> Printout or Statement of Medicare Premium or Receipt for payment of Private Health Insurance Premiums	
<input type="checkbox"/> Printout or Statement of payments from the Pharmacy and/or Out-of-Pocket Eye/Eyeglass Expenses	
<input type="checkbox"/> Letter from Health Care Facility stating date of admission, discharge, and un-reimbursed expenses for owner's care	
TOTAL UN-REIMBURSED EXPENSES	\$

CERTIFICATION *(All Owners Must Sign)*

I (We) certify that all statements made on this application are true and correct.

Signature of Owner 1	Date	Signature of Owner 2	Date
Signature of Owner 3	Date	Signature of Attorney-in-fact *	Date

* If signed by an Attorney-in-fact, a COPY of the Power of Attorney must be included with this application.

FOR ASSESSOR'S USE ONLY

- Ownership received
- Age received
- Residency received
- Income received
- Award Ltr received

Gross Income	
Un-Reimbursed Medical Deduction	-
VA Disability Deduction	-
PARTIAL TAX EXEMPTION NET INCOME	\$

DATE: _____ APPROVED DENIED Assessor's Signature/Stamp: _____

ADDITIONAL SHEETS FOR COMMENTS ATTACHED YES NO