



APPLICATION FOR TAX EXEMPTION OF RETROFITTED HANDICAPPED VEHICLES

To claim your exemption pursuant to CGS §12-81c and Local Ordinance #24 you must complete and return this application annually on or before January 31st.

Failure to file this application in a timely manner shall constitute a waiver of the right to such exemption for such assessment year.

Name of applicant: _____ Phone: _____

Responsible party (if different): _____

Complete address: _____

Year, make and model of vehicle: _____

Vehicle identification number: _____ CT DMV plate: _____

Brief description of modification: _____

******* SPECIAL INSTRUCTIONS for INITIAL APPLICATIONS *******

The following must be submitted:

1. Documentation, including a photo, which indicates how the vehicle has been altered.
2. Signed statement by a physician as to the applicant's disability.

PLEASE SEE REVERSE SIDE FOR PHYSICIAN'S AFFIDAVIT

AFFIDAVIT of FACTS:

Is this vehicle used EXCLUSIVELY for the purpose of transporting a person with disabilities? **YES** or **NO**
Is this vehicle used to transport any individual for payment? **YES** or **NO**

I do hereby declare that this vehicle is used exclusively for the purpose of transporting a person with disabilities and that I am a parent of, or a person with disabilities and the owner of the above motor vehicle, which has been specially adapted for such use.

Applicant's Signature: _____ Date: _____

Sec. 12-81c. Municipal option to exempt certain motor vehicles. The legislative body of any municipality may, by ordinance, exempt from personal property taxation (1) any ambulance-type motor vehicle which is used exclusively for the purpose of transporting any medically incapacitated individual, except any such vehicles used to transport any such individual for profit, (2) any property owned by a nonprofit ambulance company, and (3) any motor vehicle owned by a person with disabilities or owned by the parent of guardian of such person, which vehicle is equipped for purposes of adapting its use to the disability of such person, provided the legislative body of the municipality adopts a definition of such vehicle.

ASSESSOR'S OFFICE USE ONLY

APPROVED ☐ DENIED ☐* GRAND LIST: _____ ASSESSMENT: _____

*Reason for denial: _____

Received by: _____ Date: _____

PHYSICIAN'S AFFIDAVIT:

CERTIFICATION OF VEHICLE MODIFICATIONS:

I do hereby declare under penalty of false statement that the modifications to the indicated vehicle are medically necessary to permit the previously-named person with disabilities to use said vehicle.

Printed Name: _____

Title: _____

Signature: _____

Date: _____



ASSESSOR'S OFFICE

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