Owner Occupied Payment Agreement (OOPA)

Disability Verification Form –

CITY OF PHILADELPHIA
DEPARTMENT OF REVENUE

Physician's Statement of Permanent and Total Disability

注：请用英文填写表格

自住房产纳税协议（Owner Occupied Payment Agreement, OOPA）

残疾证明表- 永久及完全残疾人医生证明

A claimant not covered under the federal Social Security Act or the federal Railroad Retirement Act who is unable to submit proof of permanent and total disability may submit this Physician's Statement. The physician must determine the claimant's status using the same standards used for determining permanent and total disability under the federal Social Security Act or the federal Railroad Retirement Act. CAUTION: If the claimant applied for Social Security disability benefits and the Social Security Administration did not rule in the claimant's favor, the claimant is not eligible for an OOPA based on a disability, but may meet income eligibility limits.

《联邦社会保障法》（the federal Social Security Act）或《联邦铁路退休法》（the federal Railroad Retirement Act）未覆盖到的声明人，如果不能提交永久及完全残疾证明，可以提交这份医生证明。医生必须用和《联邦社会保障法》或《联邦铁路退休法》用以评定永久及完全残疾一样的标准来评估声明人的状况。注意：如果声明人申请了社会保障残疾福利，而社会保障局没有批准其申请，则就此种残疾情况而言，此索赔人不符合申请 OOPA 的资格，但可能符合收入资格限制。

Do not submit medical records unless requested by the Philadelphia Department of Revenue.

除非费城税务局要求，否则不要提交医疗报告。

Confidentiality Statement. All information on this Physician's Statement and claim form is confidential. The department shall only use this information for the purposes of determining the claimant's eligibility for an Owner Occupied Payment Agreement.

保密声明。此医生证明和索赔申请表上的所有信息皆为保密。费城税务局仅将这些信息用于评估声明人的自住房产纳税协议申请资格。

1 Applicant Information 申请人信息

Applicant Name 申请人姓名

OPA Account Number OPA 账号

2 Physician's Certification 医生证明

I certify the claimant named above is my patient and is permanently and totally disabled under the standards that the federal Social Security Act or the federal Railroad Retirement Act requires for determining permanent and total disability. Upon request from the Philadelphia Department of Revenue, I will provide the medical reports or records indicating diagnosis and prognosis of the claimant' s condition, including signs, symptoms and laboratory findings, if applicable or appropriate.

本人证明上述声明人是本人的患者，且根据《联邦社会保障法》或《联邦铁路退休法》评定永久及完全残疾的标准，此索赔人是永久及完全残疾的。根据费城税务局的要求，本人会提供表明此索赔人病情的诊断或预后医疗报告/医疗记录，包括体征，症状，临床发现（如适用或适当）。

Physician's Signature 医生签名 Date 日期

3 Description of Disability 残疾描述

Describe the Claimant's Permanent and Total Disability. Briefly describe the reason(s) the above-named claimant is totally and permanently disabled.请描述该声明人的永久及完全残疾状况。简短地描述上述索赔人的完全及永久残疾的原因。

4 Physician Identification Information 医生身份信息

Name 名字 National Provider Identifier 国家医疗服务提供者识别码

Business name, if applicable 公司名称，如适用

Address 地址

City 城市 State 州 Zip code 邮政编码

Office email address 办公室邮箱地址 Office telephone 办公室电话

Attach completed form to your OOPA Application

请将完整填写的表格和您的 OOPA 申请表放在一起。

Contact (215) 686-6442 with questions about this form.

如对此表有疑问，请致电（215）686-6442。