



## Information and Instructions

Claim for Exemption – Homes of Hansen’s Disease

Claim for Exemption – Homes of Blind, Deaf, or Totally Disabled

Revised Ordinances of Honolulu (“ROH”) § 8-10.6 and § 8-10.7

### 1. Eligibility for the Exemption:

All real property is exempt from real property tax up to \$25,000 of its taxable value, provided that it is:

- a. Owned by a person who is confined due to Hansen’s Disease;
- b. Owned by a person with impaired sight or hearing; or
- c. Owned by a person who is totally disabled.

Note: This exemption is separate from the home exemption allowed under § 8-10.3.

### 2. Definition of Blind, Deaf, and Totally Disabled

- a. **Blind:** A person whose visual acuity does not exceed 20/200 in the better eye with correcting lenses, or whose visual acuity is greater than 20/200 but is accompanied by a limitation in the field of vision such that the widest diameter of the visual field subtends an angle no greater than 20 degrees.
- b. **Deaf:** A person whose average loss in speech frequencies (500-2000 Hertz) in the better ear is 82 decibels, A.S.A., or worse.
- c. **Totally Disabled:** A person who is totally and permanently disabled, either physically or mentally, which results in the person’s inability to engage in any substantial gainful business or occupation. For example, medically-certified heart attack or stroke victims who are unable to engage in any substantial gainful business or occupation.

### 3. Conditions and Requirements for the Exemption Continuation

- a. Any person with **Hansen’s Disease** can retain the exemption during the temporary release period.
- b. Once filed and granted, these home and real property exemptions do not have to be refiled annually, as long as all requirements continue to be met under the definition of **Blind, Deaf, and Totally Disabled**.

### 4. How to File:

- a. Deadline: September 30 preceding the tax year for which the exemption is claimed. The exemption will be effective on July 1 of the tax year.
- b. A fillable claim form is available online at [realproperty.honolulu.gov](http://realproperty.honolulu.gov).
- c. A copy of the completed and physician-certified State of Hawaii Form N-172 must be submitted. Form N-172 is available to download on the State of Hawaii website: <https://hawaii.gov>.
- d. Please submit the completed application form in person or by mail, along with all required documents, to any of the Real Property Assessment Division (“RPAD”) offices listed below:

**Honolulu Office:** 842 Bethel Street, Basement, Honolulu, HI 96813, or

**Kapolei Office:** 1000 Ulu‘ōhi‘a Street, #206, Kapolei, HI 96707

When mailing, use First-Class, Certified, Registered, or Certificate of Mailing. Include a self-addressed, stamped envelope for a receipted copy.

The Social Security number is requested to verify the identity of the claimant. Disclosure is voluntary and will not affect the approval of the exemption claim; however, failure to provide it may delay the determination of eligibility. If provided, Social Security number will be kept confidential and used solely for purposes related to this exemption.

Disclaimer: RPAD provides general information regarding real property tax assessments. RPAD does not provide legal or other professional advice. Individuals with specific inquiries regarding ownership, real property tax law, or the appraisal process are encouraged to consult with an attorney or other qualified professional.



Parcel ID (Tax Map Key)



City and County of Honolulu  
Real Property Assessment Division  
Department of Budget and Fiscal Services  
realproperty.honolulu.gov  
Phone: (808) 768-3799

Enter 12-digit Parcel ID

**Claim for Exemption  
Homes of Hansen's Disease (ROH § 8-10.6) and  
Homes of Blind, Deaf, or Totally Disabled (ROH § 8-10.7)**

Claimant Name	Social Security Number	Date of Birth		
Site Address/Property Address	Apt. No. (if applicable)	City	State	ZIP
Mailing Address (if different from the property address) Apt. No. (if applicable) City State ZIP				
Email Address	Phone Number	Preferred Method of Contact <input type="checkbox"/> USPS Mail <input type="checkbox"/> Email <input type="checkbox"/> Phone		

**Certification and Acknowledgment**

I hereby certify that the information provided in this form and the supporting documents is true and accurate to the best of my knowledge. I understand that any false statements may result in the disqualification of the exemption and the imposition of taxes and penalties. I further acknowledge that I have read and followed the instructions for completing this form.

Print Name

Signature

Date

**For Official Use Only**

For Tax Year: \_\_\_\_\_

Approved:  Disapproved

Received By: \_\_\_\_\_

Attachments: **N-172 Form Attached**  Yes  No

Received / U.S. Postmark: \_\_\_\_\_

Building #: \_\_\_\_\_ Building Exemption %: \_\_\_\_\_ Building #: \_\_\_\_\_ Building Exemption %: \_\_\_\_\_ Land Exemption %: \_\_\_\_\_

Attachment: State of Hawaii Form N-172 – Must be completed, certified by a physician and submitted with this claim form.

STATE OF HAWAII — DEPARTMENT OF TAXATION  
**Claim for Tax Exemption by Person with Impaired  
Sight or Hearing or by Totally Disabled Person  
and Physician's Certification**



(NOTE: References to "married" and "spouse" are also references to "in a civil union" and "civil union partner," respectively.)

If you are submitting Form N-172 in response to either an adjustment letter or a collection notice, please check here ➤

**Part I Claim for tax exemption**

INDIVIDUAL:

Name of Individual

Individual's Social Security No.

Street Address of Individual

City, State & Postal/ZIP Code

who is (check applicable category)

- A person who is **blind** as defined in sec. 235-1, HRS,
- A person who is **deaf** as defined in sec. 235-1, HRS,
- A **person totally disabled** as defined in sec. 235-1, HRS,

hereby claims the benefits provided under the General Excise Tax and/or Income Tax Laws. (Check all applicable categories and provide the information requested. See separate instructions for the definitions of blind, deaf, and person totally disabled.)

- General Excise Tax (sections 237-17 and 237-24(13), HRS)

(a) General Excise Hawaii Tax I.D. No. **GE** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

(b) Doing Business As (DBA) \_\_\_\_\_

(c) Business Address \_\_\_\_\_

(d) Type of Business Activity \_\_\_\_\_

(e) Individual's Percentage of Ownership: \_\_\_\_\_; Spouse's percentage: \_\_\_\_\_

I declare, under the penalties set forth in section 231-36, HRS, that I have examined/understand the detail contents of this claim and to the best of my knowledge and belief, it is true, correct, and complete.

IN THE CASE OF A CORPORATION, PARTNERSHIP, OR LLC, THIS FORM MUST BE SIGNED BY AN OFFICER, PARTNER OR MEMBER, OR DULY AUTHORIZED AGENT.

Taxpayer Signature (individual, corporate officer, partner or member, or duly authorized agent)

Date \_\_\_\_\_

Title \_\_\_\_\_

**NOTE: DISABILITY OR IMPAIRMENT MUST BE CERTIFIED BY LICENSED PHYSICIANS,  
OPTOMETRISTS, ETC., ON THE BACK OF THIS FORM.**

Applicant's Name \_\_\_\_\_ Social Security Number \_\_\_\_\_

**Part II** Physician's or optometrist's certification. Complete only one section, even if applicant has multiple disabilities. **This form may be rejected if the appropriate section and the certification are not fully completed.** If Section A is completed, sign authorization for release of information located at the bottom of this page.

**SECTION A — EYE EXAMINATION** (Must be done by a qualified ophthalmologist or optometrist.)

1. Diagnosis \_\_\_\_\_
2. Vision 1) without corrective lenses: OD: \_\_\_\_\_ OS: \_\_\_\_\_ 2) with corrective lenses: OD: \_\_\_\_\_ OS: \_\_\_\_\_
3. Is this applicant's visual acuity 20/200 or worse in the better eye with corrective lenses?  Yes  No
4. Is the widest diameter of the field of vision less than 20 degrees?  Yes  No
5. Date first certifiable as legally "blind" (MM/DD/YYYY) \_\_\_\_\_
6. Should applicant be re-examined for tax purposes?  Yes  No If "Yes," when? \_\_\_\_\_

**SECTION B — HEARING EXAMINATION** (Must be done by a qualified otolaryngologist; i.e., Board-certified ear, nose & throat specialist, or a licensed audiologist.)

1. Diagnosis \_\_\_\_\_
2. Hearing loss (500-2000 Hertz) without aid: Right \_\_\_\_\_ Left \_\_\_\_\_ (Decibels ASA or ANSI 1969)
3. Is the applicant's average loss in speech frequencies (500-2000 Hertz) in the better ear, 82 Decibels ASA (or 92 Decibels ANSI 1969) or worse?  Yes  No
4. Date first certifiable as legally "deaf" (MM/DD/YYYY) \_\_\_\_\_
5. Should applicant be re-examined for tax purposes?  Yes  No If "Yes," when? \_\_\_\_\_

**SECTION C — REPORT ON DISABILITY** (Must be done by physicians as described in the definition for "person totally disabled" under section 235-1, Hawaii Revised Statutes.)

1. Diagnosis \_\_\_\_\_
2. Date individual came under your care \_\_\_\_\_ Date individual first disabled or unable to work \_\_\_\_\_
3. Is the individual totally disabled, either physically or mentally?  Yes  No
4. Is the disability permanent? (See "Person totally disabled" under Definitions in separate instructions.)  
 Yes What is the effective date of disability? (MM/DD/YYYY) \_\_\_\_\_  
 No When should individual be re-examined to determine extent of disability? (MM/DD/YYYY) \_\_\_\_\_
5. Is the individual able to engage in any substantial gainful business or occupation? (See "Person totally disabled" under Definitions in separate instructions.)  Yes  No
6. Pertinent symptoms or findings that preclude the individual's ability to engage in gainful work.

**CERTIFICATION BY PHYSICIAN, OPTOMETRIST, ETC.**

I hereby certify that the above applicant conforms to the State definition of "Blind," "Deaf," or "Totally Disabled." Sign this certification only if the applicant meets the applicable definition.

Date of Certification	Signature of Certifying Professional	
Professional License Number	Date License Expires	Print Name of Certifying Professional
State/Other Licensing Authority	Address of Certifying Professional	

**AUTHORIZATION FOR RELEASE OF INFORMATION BY BLIND APPLICANT**

I hereby authorize the Department of Taxation, State of Hawaii, to release my name, social security number, address, information on my eye condition and certification of my legal blindness as stated on tax Form N-172, to Ho'opono Services for the Blind Branch, Department of Human Services, State of Hawaii. The purposes of sharing this information are to maintain a State register of persons who are legally blind as mandated by section 347-6, Hawaii Revised Statutes, and to apprise me of services available from Ho'opono Services for the Blind.

Print Full Name of Blind Applicant	Date	Address of Blind Applicant
Signature of Blind Applicant or witnessed X. If signed X used, two witnesses must sign		Social Security Number of Blind Applicant
Witness #1 - Signature, If X used.		Witness #2 - Signature, If X used.