



Department of Assessments
KSC-AS-0708
201 South Jackson St.
Seattle, WA 98104-3854
206-296-3920

Senior Citizen and People with Disabilities
Reduction in Property Taxes
File Application with the King County Assessor per RCW 84.36

For property taxes due in 2024
2023 Income documents required

Maximum Combined (net) Total (2023) Income = \$84,000

1 - Application Type (check ONE or leave blank if unknown):

- ☐ New (or off program for **more** than 1 year)
☐ Reinstatement (only off program 1 year)
☐ Transfer from parcel # _____ in _____ county.
☐ Status Change: ☐ Over income ☐ Change in income ☐ Marital status ☐ Ownership ☐ Occupancy

2 - Applicant Information:

Applicant name: _____ Date of Birth: _____
First Middle Last

Spouse/domestic partner/Co-tenant: _____ Date of Birth: _____

Co-tenant = co-owner who lives on property

I am: (check appropriate box): ☐ Married ☐ Widowed (include copy of death cert.)
☐ Single ☐ Divorced/Legally separated (copy of decree, if available)

Physical address: _____ City: _____ Zip: _____

Mailing address (if different than physical address): _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____ Email: _____

3 - Age/Disability: (Proof of ID is required--such as State ID, Driver's license, Passport)

- ☐ I was 61 years of age or older on December 31, 2023. **(Copy of ID is required)**
☐ Not 61, but I have received a disability determination notice **effective prior to December 31, 2023.**
The effective date of my disability is: _____
(Include a copy of your SSI Award Letter, or Proof of Disability Form completed by your physician)
☐ Not 61, but I am a veteran with an 80% service-connected evaluation or compensated at 100% rate due to service-connected disability. **(Include a copy of your VA Compensation/Award Letter)**
☐ Not 61, but I am the surviving spouse/domestic partner of a person who was previously receiving this exemption and I was at least 57 years of age in the year my spouse/domestic partner passed away.

4 - Property Information:

Parcel or Property Tax Account Number: _____

Type of residence (Select one): ☐ Single-family residence ☐ Single unit of a multi-dwelling (duplex or condo)
☐ Co-op Housing ☐ Mobile Home in a mobile home park

This property is in the name of a Trust: ☐ No ☐ Yes, please provide a copy of your Trust.

I use my residence for business: ☐ No ☐ Yes, please provide the approx. square footage of your home used for business: _____ sq ft.

I rent out a portion of my residence: ☐ No ☐ Yes, please provide the approx. square footage of your home used for rental income: _____ sq ft.

5 - My Combined Disposable Income (CDI) range is: (check one)

- ☐ \$72,001 - \$84,000 ☐ \$60,001 - \$72,000 ☐ At or below \$60,000

6 - Property Ownership and Occupancy: **Include COPY of PURCHASE deed if recorded prior to 1992.**

Check one: ☐ I am the owner ☐ I hold a lease for life ☐ I hold a life estate for this residence.

Date property purchased: _____ Date property initially occupied: _____

I occupied the residence: ☐ More than 6 months last year (2023). ☐ Less than 6 months last year (2023).

I own another property: ☐ Yes ☐ No

If yes, where: _____

I have received an exemption before: ☐ Yes ☐ No

If yes, when: _____ where: _____

I sold my former residence: ☐ Yes ☐ No

If yes, when: _____

I sold other property in the year 2023. ☐ Yes ☐ No

If yes, where: _____

7 - Income (Combined Disposable) – **2023 Income documents are required**

COMBINED DISPOSABLE INCOME CALCULATION: Maximum Income Limit: **\$84,000**. Attach a copy of all income source documents (as indicated below) for you and your spouse/domestic partner, or co-tenant, along with a complete IRS tax return (Form 1040 & all Schedules, such as 1, B, C, D, E, etc.), if one was filed with the IRS. While ALL income sources must be disclosed, not all sources are included in the final income calculation.

Supporting documents (as indicated below) MUST accompany all self-prepared tax returns.



If you are not making an income, please provide documentation showing how you pay for daily expenses, including but not limited to January through December **2023** bank statements.

Are you required to file a federal income tax form? ☐ Yes ☐ No

Part I - Combined Disposable Income Worksheet	2023 Income
Earned wages, salaries, tips (Form 1040 line 1)– Attach Form(s) W-2	\$
Net Social Security (after Medicare is deducted)– Attach Form SSA-1099	\$
VA Disability Benefit and/or Disability Income– Attach VA or SS Award Letter	\$
Retirement, Pension, Annuity income (Form 1040 line 5a/5b)– Attach Forms 1099-R	\$
IRA (Taxable Amount) (Form 1040 line 4b)– Attach Forms 1099-R	\$
Unemployment Compensation (Form 1040 Schedule 1-line 7)– Attach Schedule 1 and 1099-G	\$
Taxable & Non-Taxable Interest and/or Dividends - (Form 1040 lines 2a, 2b & 3b)– Attach Form(s) 1099-INT and Form(s) 1099-DIV	\$
Business Income before depreciation - (Form 1040, Schedule 1-line 3)– Attach Schedule 1 and C	\$
Total Capital Gains. DO NOT deduct losses. (Form 1040 line 7)– Attach itemized Schedule D; otherwise, attach all pages of consolidated/composite 1099-B for all accounts	\$
Rental Income before depreciation - (Form 1040 Schedule 1-line 5)– Attach Schedules 1 and E	\$
Trust, Partnership, Estate or Royalty Income	\$
Taxable & Non-Taxable Bonds	\$
Gambling Winnings–(Form 1040 Schedule 1-line 8b)– Attach Schedule 1 and Form W2-G	\$
Public Assistance and Alimony Received– Attach Award statement	\$
Money received from another country– Attach proof of income docs	\$
Money received from family members– Attach letter or statement from family member	\$
Money earned by co-owner– Attach redacted copies of their income documents	\$
2023 Income Subtotal:	\$

7 – Income (*continued*)

NOTE: Failure to attach supporting income documents listed above, or paid statements/invoices for the below expenses may result in delay of processing your application or the expenses will not be deducted.



Deductions: Include amounts paid by you and your spouse or domestic partner that were NOT reimbursed by insurance or other organizations or providers. See the last page (4) for an explanation of the allowed deductions.

Part II – Non-Reimbursed Expenses (DEDUCTIONS)	Paid in 2023
1. Nursing home, assisted living or adult family home	\$
2. Home health care	\$
3. Prescription drugs	\$
4. Medicare parts A, B, C, D insurance premiums (that were not already deducted above)	\$
5. Medicare advantage/supplemental/Medigap insurance premiums	\$
6. Durable medical and mobility enhancing equipment and prosthetic devices	\$
7. Medically prescribed oxygen	\$
8. Long-term care insurance	\$
9. Cost-sharing amounts—attach a coverage summary that identifies the amount of out-of-pocket maximum. Make sure your name is printed on it.	\$
10. Nebulizers	\$
11. Medicines of mineral, animal and botanical origin prescribed, administered, dispensed by a naturopath licensed under Washington law	\$
12. Ostomic items	\$
13. Insulin for human use	\$
14. Kidney dialysis devices	\$
15. Disposable devices used to deliver drugs for human use	\$
16. Adjustment to income (Form 1040 line 10-> Schedule 1 Part II line 26)	\$
Attach Schedule 1 Part I & II	
2023 Total Deductions	\$
(Your Income Subtotal – (minus) the total deductions) = 2023 NET TOTAL INCOME	\$

Maximum Combined (net) Total (2023) Income = \$84,000

8 - Certification/Signature:

By signing this form, I confirm that I:

- Have completed the income section of this form and all proof of income is included.
- Understand it is my responsibility to notify the King County Assessor's office if I have a change in income or circumstances and that any exemption granted through erroneous information is subject to the correct tax being assessed for the last five years, plus a 100% penalty.
- Declare under penalty of perjury that the information in this application packet is true and complete.
- Request a refund under the provisions of RCW 84-69-020 for taxes paid or overpaid as a result of mistake, inadvertence, or lack of knowledge regarding exemption from paying real property taxes pursuant to RCW 84.36.381 through 389.

Signature of applicant: _____ **Date:** _____

❶ If signed by Power of Attorney (POA), a copy of a signed POA must be attached.

❶ For security reasons, please **DO NOT EMAIL** your personal information and application to our office.

❶ It is recommended that you redact (use a marker to cover) your Social Security number and all account numbers on your documents before mailing them to our office.

Non-Reimbursed expenses/deductions:

(Explained in the order it appears on the expenses worksheet in Section 5 Part II on page 3)

1. **Enter nursing home, assisted living facility, or adult family home expenses incurred.** Provide copies of paid invoices or equivalent documents for the amounts entered.
2. **Enter home health care expenses incurred.** Home health care means the treatment or care received in the home that is similar to the type of care provided in the normal course of treatment or care in a nursing home. The providers of home health care do not have to be licensed for the cost to be deductible under the provision. **Qualifying expenses may be** physical therapy received in the home, medical treatments or care received in the home, attendant care, light housekeeping tasks, meals-on-wheels, or life alert. Provide copies of paid invoices or equivalent documents for the amounts entered.
3. **Enter the amounts paid for prescription drugs.** Provide a year-end statement from your pharmacy showing what you paid out-of-pocket for non-reimbursed prescription drugs.
4. **Enter the amounts paid for Medicare Parts A, B, C, or D insurance premiums.** Provide copies of SSA-1099, invoices, or equivalent documents for amounts entered.
5. **Enter the amounts paid for approved Medicare supplemental insurance premiums.** Provide copies of statements identifying insurance company, plan number, and premiums paid.
6. **Enter amounts paid for durable medical equipment, mobility enhancing equipment, and prosthetic devices.** Deductible amounts include for purchase, rental, repair, cleaning, replacement parts, etc. **Review WAC 458-20-18801 tables 1, 3 and 5 for qualifying items.** Provide receipts or invoices for amounts entered.
7. **Enter amounts paid for medically prescribed oxygen, including but not limited to, oxygen concentrator systems, oxygen enricher systems, liquid oxygen systems, and gaseous, bottled oxygen systems prescribed.** Provide receipts or paid invoices for amounts entered.
8. **Enter amounts paid for long-term care insurance premiums.** Provide paid invoices or equivalent documents for amounts entered.
9. **Enter amount paid for cost-sharing. Cost-sharing amounts included deductibles, co-insurance, co-payments for enrollees in health plan; the amounts counted toward the plans out-of-pocket maximum.** Provide a coverage summary that identifies the amount of out-of-pocket maximum entered. Make sure your name is printed on it.
10. **Enter amounts paid for nebulizers; a device, not a building fixture, that converts a liquid medication into a mist so that it can be inhaled.** Provide receipts or paid invoices for amounts entered.
11. **Enter amounts paid for medicines of mineral, animal, and botanical origin prescribed, administered, dispensed, by a naturopath licensed under Washington law.** Provide receipts or paid invoices for amounts entered. Include a copy of the treatment plan, and the name of the naturopath and their Washington license number.
12. **Enter the amounts paid for ostomic items: disposable medical supplies used by colostomy, ileostomy, and urostomy patients, and includes bags, belts to hold up bags, tapes, tubes, adhesives, deodorants, soaps, jellies, creams, germicides, and other like supplies.** **Does not include** undergarments, pads and shields to protect undergarments, sponges or rubber sheets. Provide receipts or invoices identifying items and amounts paid.
13. **Enter amounts paid for insulin for human use.** Provide receipts or invoices identifying items and amounts paid.
14. **Enter amounts paid for kidney dialysis devices.** Provide receipts or invoices identifying items and amounts paid.
15. **Enter amounts paid for disposable devices used to deliver drugs such as syringes, tubing, or catheters.** **Does not include** a stand or device that holds the tubing or catheter. Provide receipts or invoices identifying items and amounts paid.
16. **Adjustments to income.** Refer to your Federal Form 1040 line 10. This amount should be from Schedule 1 of your Form 1040, Part II line 26. Provide a copy of your complete 1040, including Schedule 1.

Please mail your application and redacted documents to:

Department of Assessments

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201 S. Jackson St.

Seattle, WA 98104