AR1000RC5 2015

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ARKANSAS INDIVIDUAL INCOME TAX

CERTIFICATE FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES

Taxpayer's Name	Taxpayer's Social Security Number
Spouse's Name	Spouse's Social Security Number

This certificate must be completed in its entirety to receive the $500 credit for individuals with developmental disabilities. It must be attached to your individual income tax return the first time this credit is taken. It is good for five (5) years from the date the original tax credit is filed. At the end of five (5) years you must have a new certificate completed and attached to your individual income tax return. The credit is in addition to your regular dependent tax credit.

To take advantage of this credit, the individual with a developmental disability **must meet all of the following conditions:**

1. Was the individual a person of the taxpayer's blood or an adopted child without regard to chronological age or a dependent within the meaning of ACA 26-51-501(a)(3)(B)? ☐ Yes ☐ No
2. Did the individual reside in your home more than one-half of the tax year? ☐ Yes ☐ No
3. Was the individual dependent on the taxpayer for over one-half of his/her support during the tax year? ☐ Yes ☐ No
4. Did the developmental disability originate before the individual attained the age of 22? ☐ Yes ☐ No
5. Will the developmental disability continue or can be expected to continue indefinitely and constitute a substantial impairment to the individual's ability to function without appropriate support services including, but not limited to, planned recreational activities, medical services such as physical therapy and speech therapy, and possibilities for sheltered employment or job training? ☐ Yes ☐ No

Qualifying Individual's Name _____ Social Security Number _____ Relationship to Taxpayer _____

Check the box for the diagnosis:

DO NOT ADD ADDITIONAL BOXES

☐ Cerebral Palsy ☐ Epilepsy ☐ Autism ☐ Down Syndrome ☐ Spina Bifida

☐ Intellectual Disability

The above individual has been diagnosed with a developmental disability by a licensed physician, a licensed psychologist, or a licensed psychological examiner. I certify that the information listed above is true and correct.

Initial Diagnosis Date _____

Doctor or Examiner's Signature _____ Date _____

Doctor or Examiner's Name _____ Telephone Number _____

Street Address _____ City _____ State _____ Zip _____

Taxpayer's Signature _____ Date _____

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