

SOUTH CAROLINA COMMISSION ON HIGHER EDUCATION STUDENTS WITH DISABILITIES TUITION TAX CREDIT VERIFICATION

CHE-400

(9/1/05)

Date:	Tax Year in which you are filing	g: (January 1 - December 31)
Part I. Taxpayer Information		
Last Name:Social Security Number:	First Name:	M.I.:
Social Security Number:		
Mailing Address:		
Phone Number: ()	<u></u>	
Part II. Student Information		
Last Name:Social Security Number:	First Name:	M.I.:
Mailing Address:		
Phone Number: ()		
South Carolina Institution of attenda	nce:	
Part III. Disability Services Provider The Disability Services Provider at		st complete Part III. If the student attended more tha
		leted for each institution of attendance and must b
verified by the Disability Services Pr		
Name:	Title:	
Institution:		
Office:		_
Rehabilitation Act of 1973 as a student semesters. I have determined that	dent with a disability prior to eac this student was unable to su wa	nericans with Disabilities Act and Section 504 of the semester of enrollment (Spring, Summer, and Faluccessfully complete 30 credit hours (or credit hours approved to enroll in less than 30 credit hours (cters.
Signature, Disability Services Provide	ler Date	
	quirements for the Tuition Tax C e. I hereby certify that the above	redit are met in accordance with Section 2. Article 25 e Disability Services Provider has determined that the verified disability.
Student Signature (required)	Date	
Parent / Legal Guardian (required)	 Date	

This document must be attached to the South Carolina Department of Revenue Tuition Tax Credit Form (I-319) and submitted together with the SC1040.