PRINT FORM CLEAR FORM

AR1000-DD

Formerly AR1000RC5

ITDD231

ARKANSAS INDIVIDUAL INCOME TAX

CERTIFICATE FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES

Primary's legal name	Primary's social security number
Spouse's legal 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. This certification is good for the life of the dependent. The credit is in addition to your regular dependent tax credit. This credit is a non-refundable credit and only reduces your tax liability by 500 dollars.

Must be completed by taxpayer

Developmentally disabled dependent's name _____ Social security number _____ Relationship to taxpayer _____

By signing below I certify that the dependent listed is not eligible to be claimed by another taxpayer.

Taxpayer's signature _____ Date _____

Must be completed by a licensed physician, a licensed psychologist, or a licensed psychological examiner

Check the box for the diagnosis:

DO NOT ADD ADDITIONAL BOXES

☐ **Autism** ☐ **Cerebral Palsy** ☐ **Down Syndrome** ☐ **Epilepsy** ☐ **Intellectual Disability** ☐ **Spina Bifida**

1. Did the above condition originate prior to age of 22? ..... ☐ Yes ☐ No

2. 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

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. Physician signature and address stamps are acceptable.

Initial diagnosis date _____ Date of birth _____

Doctor or examiner's signature _____ Date _____

Doctor or examiner's name _____ Telephone number _____

Street address _____ City _____ State _____ Zip _____