

COUNCIL TAX
APPLICATION FOR DISCOUNT DISREGARD/EXEMPTION
ON GROUNDS OF
SEVERE MENTAL IMPAIRMENT

Notes:

1. The applicant must complete Parts 1 to 4 only.
2. Once the applicant has completed Parts 1 to 4, please pass the completed form, to the doctor.
3. The doctor must complete part 5.
4. Once the doctor has completed Part 5, he/she must return the completed form to this office.
5. Should the claimant meet the criteria for this application, the discount/exemption will be awarded from the date the doctor agreed in part 5a, a revised Council Tax demand will be issued separately.

Part 1
Benefit Conditions

I declare that the claimant is in receipt of one or more of the following benefits or allowances or was entitled to one or more of them until he/she reached the state retirement age.

Please tick the appropriate box.

- | | |
|-------------------------------------------------------------------------------------------------------------------------|--------------------------|
| ➤ Income Support (including a disability premium on the grounds that the claimant is incapable of work). | <input type="checkbox"/> |
| ➤ Incapacity Benefit. | <input type="checkbox"/> |
| ➤ Severe Disablement Allowance. | <input type="checkbox"/> |
| ➤ Unemployment Supplement (payable as an increase to disablement benefit). | <input type="checkbox"/> |
| ➤ Unemployment Allowance (payable with a war disablement pension). | <input type="checkbox"/> |
| ➤ Attendance Allowance (at the higher or lower rate). | <input type="checkbox"/> |
| ➤ Constant Attendance Allowance (at one of the four rates payable with disablement benefit or war disablement pension). | <input type="checkbox"/> |
| ➤ The Care component of Disability Living Allowance (payable at the higher or middle rate). | <input type="checkbox"/> |
| ➤ An increase in the rate of disablement pension.
Disability Working Allowance. | <input type="checkbox"/> |
| ➤ Employment Support Allowance. | <input type="checkbox"/> |

Proof of the relevant benefit or allowance MUST be provided before the claim can be processed.

Part 2 Claimant's Details

Surname:

First Names:

Account Number (if known):

Address:

Daytime Telephone Number: _____

Date of Birth (only necessary if claimant is under 18): _____

Are you the sole resident (over the age of 18) in the property?

Yes

No Please provide names of all other residents

Part 3 Declaration

I declare that, to the best of my knowledge, the information provided on this application form is true.

Signature: _____

Date: _____

If a person, other than the claimant, has completed this form please complete this section.

Full name: _____

Address: _____

Relationship to claimant: _____

Part 4 Authorisation to approach Doctor

I give my consent that Basingstoke & Deane may approach my doctor at any time to discuss my application for a discount disregard/exemption.

Doctor's name: _____

Doctor's address: _____

Signature of person who completed the declaration in part 2: _____

Part 5 To be completed by Registered Medical Practitioner

Doctor's Surgery/Hospital Address: _____

Part 5a

I certify that in my opinion, the applicant named in Part 1 of this form:

is from
is not
Day Month Year

Suffering from severe mental impairment for the purposes of the Local Government Finance Act 1992. For the purpose of the Act a person is severely mentally impaired 'if he has a severe impairment of intelligence and social functioning (however caused) which appears to be permanent', This definition applies only for this Act and is not the same as the definition 'Severe mental impairment' in the Mental Health Act 1983.

Doctor's signature: _____

Date: _____

Doctor Surgery/Hospital Stamp: _____

Please note this application will be declined without a stamp from your Doctor.

Please forward the completed application to the Local Tax Office at Basingstoke and Deane PO Box 191 London Road Basingstoke RG21 7EA