

Application for for Council Tax Severley Mentally Impaired Discount/Exemption

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| Name of person making application | |
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| Name of Severely Mentally Impaired person <small>(if different from above)</small> | |
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| | |
|-------------------------|--|
| Reference Number | |
|-------------------------|--|

| | |
|----------------|--|
| Address | |
|----------------|--|

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|--|--|
| Start date for discount/exemption | |
|--|--|

A person is disregarded for council tax if he or she is severely mentally impaired and is stated to be such in a certificate from a registered medical practitioner.

They must also be entitled to one of the following state benefits.

- a) Incapacity Benefit
- b) Attendance Allowance
- c) Severe Disablement Allowance
- d) The care component of a disability living allowance payable at either the highest or middle rate
- e) An increase in the rate of disablement pension
- f) A disability working allowance
- g) An unemployability supplement
- h) A constant attendance allowance
- i) An unemployability allowance
- j) Income Support where the applicable amount includes a disability premium

(The above descriptions of the qualifying benefits are necessarily abbreviated in some respects)

- 1) Please tick to confirm that you are enclosing proof of one of the qualifying benefits listed above.
We will not be able to process the application without this.
- 2) **How many adults are resident in the property? _____**
Please list the adults resident in the box below indicating which are Severely Mentally Impaired.

| Name of Resident | Severely mentally Impaired Y/N |
|------------------|--------------------------------|
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- 3) **Please ensure a registered medical practitioner (such as a doctor) signs the declaration below.**
Declaration by a Registered Medical Practitioner: I declare that the above named has a severe impairment of intelligence and social functioning (however caused) which appears to be permanent and should therefore be classed as severely mentally impaired.
 Please confirm the date that the patient became severely mentally impaired.
Effective date of impairment.....
Signed.....Position.....Date.....

- 4) **Declaration:**
 I declare that the information stated above is true to the best of my knowledge. I understand that I must contact the Revenues Section within 21 days if my circumstances change.
Signed.....Full Name.....
Date.....Telephone Number.....