



**COUNCIL TAX DISCOUNT/EXEMPTION APPLICATION
Severely Mentally Impaired People**

Name & Correspondence Address	Property Address
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.....

You have indicated that there is someone who normally lives in your home who should be disregarded for Council Tax purposes.

For this purpose a person is considered to be severely mentally impaired if he or she 'has a severe impairment of intelligence and social functioning (however caused) which appears to be permanent'.

To qualify for this discount/exemption the applicants must be entitled to at least one of the benefits listed on the application form, or (in the case of benefit which ceases to be payable on reaching pensionable age) have been entitled to the benefit until it ceased for that reason, or have a partner who received Job Seekers allowance which is increased on the grounds of that person's incapacity to work.

If the member of your household whom you consider to be severely mentally impaired is entitled to any of these allowances, I must still get a certificate from his or her general practitioner or any other registered medical practitioner who knows the applicant.

Can you please complete the enclosed form giving the details requested and return the form to me. I will then get in touch with the doctor named and let you know the result of your application as soon as I can. The information supplied on the form will be used for the purpose(s) for which you have supplied it, and, where appropriate, will also be used by the Council in carrying out its various functions effectively. It will not be shared with other organisations unless we are required to do so by law. However the Council will always use or share information for the prevention or detection of crime, or the apprehension or prosecution of offenders

I am sorry if this procedure seems to be bureaucratic and I hope that it will not cause you or the applicant any undue worry or distress.



Council Tax Discount/Exemption Application

Severely Mentally Impaired People

Property Address

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PART 1

On behalf of the applicant. Please complete section A and B of this application form along with any appropriate evidence.

I will then seek confirmation on the applicant's behalf of their medical condition in accordance with the authorisation at B below by requesting your doctor completes Part II.

Please return this form direct to Revenue Services, South Norfolk Council, Swan Lane, Long Stratton, Norwich, NR15 2XE. Do not send this form direct to the Doctor

Applicant's Name

Date of birth

A. Benefit Entitlement *(Please tick the appropriate box to indicate which benefit(s) the applicant is entitled to)*

I declare that the applicant is entitled to

- | | |
|---|--|
| <input type="checkbox"/> Incapacity benefit | <input type="checkbox"/> Attendance allowance at the higher or lower rate |
| <input type="checkbox"/> Constant attendance allowance | <input type="checkbox"/> Severe disablement allowance |
| <input type="checkbox"/> Constant attendance allowance at one of four rates payable with disablement benefit or war disablement pension | <input type="checkbox"/> Unemployment supplement payable as an increase to disablement benefit |
| <input type="checkbox"/> Unemployability allowance payable with war disablement pension | <input type="checkbox"/> Income support disability premium awarded on the grounds of incapacity for work |
| <input type="checkbox"/> The care component of the disability living allowance, higher or middle rate | <input type="checkbox"/> Incapacity benefit under sections 40 and 41 of the Social Security Contribution and Benefits Act 1992 |
| <input type="checkbox"/> Disabled person's tax credit (disability working allowance) | <input type="checkbox"/> Applicants partner receives an increased rate of Job Seekers Allowance because of the applicants incapacity to work |

I enclose evidence of the above entitlement *(Such as a letter of entitlement)*

B. Authorisation

I authorise you to seek on the applicant's behalf the certificate set out in Part II below from the following registered medical practitioner*.

I agree that the certificate should be returned direct to you, with a copy for transmission to me.

Applicant's Name	
Applicants Address	
Doctor's Name	
Doctor's surgery/hospital address	
Signature <i>(person acting on applicants behalf)</i>	Date
Full Name	
Relationship to applicant	
Address	

* This will normally be the applicants general practitioner. Any certificate issued by the general practitioner will be for the use **ONLY** in applying for a discount/exemption for Council Tax purposes.

Part II (To be completed by registered medical practitioner)

Please tick appropriate box:

I certify that in my opinion the applicant named in Part I of the form above is is not suffering from severe mental impairment for the purpose of the Local Government Finance Act 1992, and has been since

Doctor's signature

Doctor's full name *(in block capitals)*

Doctor's status

Date

TO THE DOCTOR:

Please return this form to Council Tax Department, South Norfolk Council, Swan Lane, Long Stratton, Norfolk NR15 2XE. We will forward one copy to the applicant or his representative and retain the principal copy for our own use. The certificate is for the use **ONLY** in applying for a discount/exemption for Council Tax purposes.