STROUD DISTRICT COUNCIL

Council Offices • Ebley Mill • Ebley Wharf • Stroud • GL5 4UB

www.stroud.gov.uk Email revenue.services@stroud.gov.uk

COUNCIL TAX DISCOUNT APPLICATION
SEVERE MENTAL IMPAIRMENT

Account reference:
Date:

THIS APPLICATION SHOULD BE COMPLETED BY THE PERSON WHO WILL BE LIABLE TO PAY THE COUNCIL TAX.

You do not legally have to provide the information asked for in this form. However, without the necessary information, we will be unable to assess your claim.

PLEASE READ THE FOLLOWING BEFORE COMPLETING THIS APPLICATION FORM

The full Council Tax bill assumes that there are two or more adults living in a household.

Certain people will not be counted when looking at the number of adults resident in a household.

Before applying for this discount, you should count the number of adults in your household who **are not** in one of the special groups listed below.

If you are left with two or more adults, we will be unable to consider your application, and the full charge will be payable.

Please complete the following:

Number of adults in your household	☐
Number of adults who are in one of the discounted groups (students, apprentices, long term hospital patients, student nurses, carers, prisoners, severely mentally impaired etc.)	☐

NOTE TO THE APPLICANT

To qualify for this discount a member of your household must be entitled to one of the benefits listed and also be certified by a doctor to be suffering from severe mental impairment.

Please complete: PARTS 1 AND 2, ask a medical practitioner to complete PART 3 and then return the form (together with proof of the relevant benefit) to Stroud District Council, Council Offices, Ebley Mill, Stroud, GL5 4UB.

ALL PARTS OF THE FORM MUST BE COMPLETED BEFORE RETURNING TO US.

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PART 1

(Please complete this form in **BLOCK CAPITALS** using a ball-point pen.)

NAME OF SEVERELY MENTALLY IMPAIRED PERSON

SURNAME.....FORENAME(S).....
ADDRESS.....
.....
.....
.....
.....POSTCODE.....

DECLARATION OF BENEFIT CONDITIONS

Please tick

I declare that he/she

(a) is entitled to invalidity pension ☐
(b) is entitled to attendance allowance ☐
(c) is entitled to severe disablement allowance ☐

(d) is entitled to the standard or enhanced rate of the daily living component of the personal independence payment ☐
(e) is entitled to an increase in the rate of disablement pension where constant attendance is needed ☐
(f) is entitled to a disability working allowance ☐
(g) is entitled to unemployability supplement ☐
(h) is entitled to a constant attendance allowance ☐
(i) is entitled to incapacity benefit ☐

The applicant has been entitled to the above benefit since _____ (please give exact date)

You must provide proof of the benefit (for example, a copy of the award letter) as we cannot proceed without that.

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PART 2

FULL NAME OF PERSONS COMPLETING THIS FORM

SURNAME.....FORENAME(S).....
RELATIONSHIP TO APPLICANT.....
ADDRESS (IF DIFFERENT FROM PART 1).....
.....
DATE SIGNATURE

Note:
IF SOMEONE JOINS YOUR HOUSEHOLD OR REACHES THE AGE OF 18 IT MAY AFFECT YOUR ENTITLEMENT TO THIS DISCOUNT. YOU MUST, THEREFORE, NOTIFY STROUD DISTRICT COUNCIL IMMEDIATELY OF ANY CHANGES TO YOUR HOUSEHOLD.

PART 3 (To be completed by a registered practitioner.)

I certify that in my opinion the applicant named in PART 1 of the form

is ☐ and has been since_____

is not ☐ (please tick appropriate box) suffering from severe mental impairment for the purpose of the Local Government Finance Act 1992.

DOCTOR'S FULL NAME.....
DOCTOR'S SURGERY/HOSPITAL ADDRESS.....
.....
…….....POSTCODE.....

DATE..... DOCTOR'S SIGNATURE.....

DOCTOR'S STAMP:

IF YOU HAVE ANY DIFFICULTY IN COMPLETING THIS FORM, PLEASE RING THE COUNCIL TAX HELPLINE ON STROUD (01453) 766321