01789 260990
revenues@stratford-dc.gov.uk

Hannah Buckley
Head of Housing, Revenues and Customer Services

Direct Line :

Email :

My Ref :

Your Ref :

Date :

Council Tax Discount/Exemption-Persons Suffering Severe Mental Impairment
*****Please return completed form to the council, not to the doctor*****

PART 1

Your name

Your relationship to the person named in Part 2

Account Reference

Property Address

How many people aged 18 years or over live at this address?

PART 2 refers to a member of your household who is suffering from severe mental impairment

(a) The person's name and address

Name:
Address:

Allowances/Pensions received (**please circle as appropriate**)

Employment Support Allowance
Attendance Allowance
Severe Disablement Allowance
Constant Attendance Allowance
Increased Disability Pension
Unemployability Supplement/Allowance
Personal Independence Payments
Incapacity Benefit
Armed Forces Independence Payments
Income Support that includes a disability premium
The Care Component of High or Middle Rate Disability Living Allowance
Universal Credit including Health Element or Limited Capability for Work Element

Please send with this claim, a letter from the Department of Work and Pensions (DWP) confirming the date that entitlement started. It will be sent back by return of post. Without this letter your claim cannot be processed.

(b) The name of their doctor

Surgery or hospital address

PART 3

Authorisation and Declaration

I authorise you to seek confirmation from the named doctor of the medical condition of the person named in Part 2(a). I declare that the information on this form is correct and completed to the best of my knowledge. I agree that the Council may make any enquiries to check information. I agree to inform the Council of any change in circumstances which could affect this application. I understand that any false declaration given by me can result in prosecution under the Fraud Act 2006.

Signature of applicant

Your contact number

Having completed Parts 1, 2 and 3 of this form, please send it to the address at the bottom of this letter, remembering to enclose the letter of entitlement.

PART 4

To be completed by the registered medical practitioner who is named in Part 2(b).

I certify in my opinion the person named in Part 2(a) of this form

is/is not* suffering from severe mental impairment with effect from _ _ / _ _ / _ _

A person is severely mentally impaired if they have a severe impairment of intelligence and social functioning, however caused, **which appears to be permanent.** Please refer to the Local Government Finance Act 1992 Schedule 1.

Doctor's signature _____ Dated _ _ /_ _ /_ _

Doctor's name (BLOCK CAPITALS) _____

Doctor's surgery address stamp

TO THE DOCTOR
Please return entire form to the address at the bottom of this letter.

Please note that in accordance with the Department of Heath advice letter of March 1993 PL/CO(93) 1, and The National Health Service (General Medical Services) Amendment Regulations 1993, **no fee should be charged for this certification.**

Please return to: Revenues Department, Stratford on Avon District Council, Elizabeth House, Church Street, Stratford-upon-Avon, Warwickshire. CV37 6HX

Privacy notice: We will use your personal data to assess and administer your Council Tax. We may share your information with other departments in the substantial public interest and in the exercise of our official authority. Your data will be held in accordance with our Retention and Destruction Policy. For further information, or to access your information rights, please visit www.stratford.gov.uk/privacy or write to our Data Protection Officer at our Elizabeth House address or email data.protection@stratford-dc.gov.uk or call 01789 267575.