**Council Tax**

**Application to be Disregarded (Severely Mentally Impaired)**

**Part A – Details of the applicant (the severely mentally impaired person)**

Account Ref: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Property Ref: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Property Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Daytime Tel. No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name(s) of all other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

adults resident:

Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Part B - To be completed by a registered medical practitioner i.e. a Doctor, GP or Advanced Nurse Practitioner.**

Please confirm whether or not this individual meets each of the following criteria

They have a severe impairment of intelligence Yes\_\_\_\_ No\_\_\_\_

They have a severe impairment of social functioning Yes\_\_\_\_ No\_\_\_\_

Both of these appear to be permanent Yes\_\_\_\_ No\_\_\_\_

Note: If all three criteria are not met please do not complete this form any further

**I declare that the person named in Part A meets the above criteria and has done so**

**from \_\_\_\_\_\_\_\_\_\_\_\_\_ (please insert exact date).**

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Practice/Hospital Stamp

Print name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Part C – To be completed by, or on behalf, of the applicant**

**The applicant is entitled to the following benefit or allowance**

|  |  |
| --- | --- |
|  | Incapacity Benefit |
|  | Employment Support Allowance |
|  | Severe Disablement Allowance |
|  | Unemployment Supplement/Allowance paid with a war pension or industrial injuries |
|  | Constant Attendance Allowance paid with a war pension or industrial injuries |
|  | Disability Living Allowance Care at middle or high rate |
|  | Standard or Enhanced rate of the Daily living component of Personal Independence Payment |
|  | Standard or Enhanced rate of the daily living component of Adult Disability Payment |
|  | Attendance Allowance |
|  | Income support with the Disability Premium on incapacity grounds |
|  | Working Tax Credit that includes the Disability Element |
|  | Universal credit |
|  | Is over state pension age and would have been entitled to one of the above benefits if under state pension age |

Date the above benefit or allowance started\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**You must provide proof of your entitlement to the qualifying benefit or allowance to enable us to process your application.**

**I authorise the following person to act on my behalf**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Daytime Tel. No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wish all future correspondence be issued to the above person? \_\_\_\_\_\_\_\_\_

**Declaration - To be signed by the liable person**

* Ideclare that the information on this application is correct**.** I will notify you immediately of any changes that might affect my Council Tax or the category of exemption claimed.
* I understand that giving false information is an offence for which a penalty can be imposed and you may check the information with other sources as allowed by the law.
* I understand that any information I have provided will be used in the administration of my Council Tax account. You may give information to other parties where the law allows this.

Signed: Date:

**Where to return form too**

**Please either post or email this form with required evidence using details shown below.**

Dumfries and Galloway Council, Enabling and Customer Services, Local Taxation Team,

PO Box 9089, Dumfries, DG1 9EB

Telephone number 030 33 33 3005, Email [Council.Tax@dumgal.gov.uk](mailto:Council.Tax@dumgal.gov.uk) or visit our website  [www.dumgal.gov.uk/counciltax](http://www.dumgal.gov.uk/counciltax)

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