



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**

Council Tax Account reference:

Date:

Scan code: CDISIMI

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 contact the Council Tax helpline on 01453 754865 if you have any questions regarding this form.

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 bill 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

In order 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 to Stroud District Council at the address shown above together with proof of the relevant benefit.



2002-2003
Crime Reduction in Rural Areas
2004-2005
Services for Older People

Chief Executive: David Hagg





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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 unemployment 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) and provide proof of the benefit.

PART 2

FULL NAME OF PERSONS COMPLETING THIS FORM

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



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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.

BEFORE RETURNING THIS FORM TO STROUD DISTRICT COUNCIL PLEASE CHECK THAT ALL SECTIONS HAVE BEEN COMPLETED AND PROOF OF THE RELEVANT BENEFIT ENCLOSED. FAILURE TO DO SO WILL RESULT IN THE FORM BEING RETURNED TO YOU FOR COMPLETION.

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 **AND** STAMP.....



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