

Date of Issue

Property Reference

Account Reference

Regarding Address

COUNCIL TAX - SEVERE MENTAL IMPAIRMENT DISREGARD

Part 1 - TO BE COMPLETED BY THE APPLICANT'S GUARDIAN

On behalf of the applicant, please complete sections A, B & C below, and ensure Part 2 of the form is completed by his/her registered medical practitioner before you return the form. You will be required to provide documentary evidence of entitlement to benefit. We will then, in appropriate cases, seek confirmation on the applicant's behalf of his/her medical condition in accordance with the authorisation at C below.

A General Details

1. Name of person who may qualify for exemption....
- 2 Total number of Adults resident in property.....

B Declaration on benefit conditions

I declare that the applicant is entitled to or receiving:
(Please tick appropriate box or boxes, complete the Start date of benefit / allowance box and supply a copy of the letter from the Department of Work and Pensions from the earliest date to verify their entitlement to this benefit.)

1. Incapacity Benefit or Employment Support Allowance.....
2. Attendance Allowance.....
3. Severe Disablement Allowance.....
4. The care component of the Disability Living Allowance at the highest or middle rate or the standard or enhanced rate of the daily living component of the Personal Independence Payment...
5. An increase in the rate of Disablement Pension.....
6. Disability Working Allowance.....
7. Unemployability Supplement.....
8. Constant Attendance Allowance.....
9. Unemployability Allowance.....

Start date of benefit / allowance..... / /

Part 1 (continued) - TO BE COMPLETED BY THE APPLICANT'S GUARDIAN

C Authorisation To Obtain Further Information

I authorise you to seek on the applicant's behalf the certificate set out in Part 2 from a registered medical practitioner. I agree that the certificate should be returned direct to you as the Council Tax Officer, with a copy for transmission to me.

Doctor's name
Doctor's Surgery / Hospital address

Signature of person acting on applicant's behalf	Date
Full Name in BLOCK CAPITALS	
Relationship to applicant	
Address	
Post Code	Telephone number

Part 2 - TO BE COMPLETED BY A REGISTERED MEDICAL PRACTITIONER

Doctor's Surgery / Hospital address (if different from part 1)

I certify that in my opinion the applicant named in Part 1 of this form is severely mentally impaired, i.e. has severe mental impairment of intelligence and social functioning, which appears to be permanent as specified in the Local Government Finance Act 1992.

He / she has been suffering from this condition since.....

	/	/
--	---	---

Doctor's signature	Date
Doctor's full name in BLOCK CAPITALS	
Doctor's status	

To the Doctor: Please return the principal copy of this form to the Council Tax Officer. A copy may be retained for the Doctor's records. The certificate is for use only in applying to be disregarded for the purpose of Council Tax.

How we will use your information

Your information will be used so that we can administer your account and collect Council Tax from you in accordance with the Local Government Finance Act 1992. Under Article 6(1) (e) of the General Data Protection Regulations, we are permitted to use data for our tasks; data protection law describes this legal basis for handling your information. It will be used by North West Leicestershire District Council and our partners to deliver and improve services and fulfil our statutory duties. We will not disclose any personal information to any other third parties unless required or allowed to do so by law. Read more about how we use personal data on our privacy notice page https://www.nwleics.gov.uk/pages/data_protection_notice or write to the council at North West Leicestershire District Council, Council Offices, Coalville, Leicestershire LE67 3FJ Telephone: 01530 454545.