

Council Tax - Claim for Discount/Exemption The Severely Mentally Impaired

Please visit our website at www.sandwell.gov.uk/counciltax for full details of the regulations relating to this reduction.

Who is claiming?

Full Name person who qualifies for Severely Mentally Impaired reduction	
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Claimants National Insurance Number	
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Claimants Council Tax Account Number	
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Where does the Severely Mentally Impaired person live?

Full Address	
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Number of adults (18 or over) living at the property?		Number of residents who are Severely Mentally Impaired?	
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What Benefits do they receive?

Type of benefit received	
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Date on which this benefit commenced	/ /
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Please note that proof of receipt of the above Benefit is required. It is essential that you provide with this claim a letter of confirmation from the Department of Work & Pensions

Where criteria is met and the appropriate benefits are payable, any reduction will only be granted from the earliest date of payment shown on the Letter from DWP provided. Where further backdate is required, additional/further evidence of benefit payments must be supplied.

Who is their Doctor?

Doctors Name	
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Doctors/Hospital Address	
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If you are acting on behalf of the person named above, please complete below

Your Name

Your Address

Relationship to Claimant

Your Telephone Number

Your Email address

DECLARATION - which must be completed by, or on behalf of, the liable resident

I declare that the information given above is true and accurate to the best of my knowledge and belief. I undertake to notify the Revenues and Benefits Service of any change in circumstances, which could affect my entitlement to a Council Tax reduction. I understand that if my circumstances relating to liability, discount or exemptions change, I must notify the Council Tax office within 21 days. In addition, I am aware that I must not knowingly provide false information. I understand that failure to meet these requirements could result in a £70 fine (penalty) being added to my Council Tax account

Full Name _____

Telephone Number _____ Email address _____

Signature _____ Date _____

Now ask the claimants doctor to confirm they meet the Severely Mentally Impaired criteria

- Complete Part 1 of the attached Medical Practitioner Authorisation Form.
- Ask the claimants doctor to complete Part 2 of the Medical Practitioner Authorisation Form.

In order for us to consider your claim it is important that we receive the following:

- Your fully completed claim form
- Letter of confirmation from the Department of Work & Pensions to confirm qualifying Benefit
- Fully Completed Medical Practitioner Authorisation Form

Once you have all the above information please return to us using the enclosed Freepost envelope.

Please Note: Where there is a legitimate reason to do so information which is collected for the administration of Council Tax may be shared with other departments within Sandwell Council.

Council Tax - Claim for Discount/Exemption Severely Mentally Impaired Authorisation to Medical Practitioner

PART 1 – Authorisation from claimant for Doctor to release information to the Council

Name of Patient	
Patient's Address	
Patient's Doctor	
Name of person acting on patients behalf	
Relationship to patient	

I authorise you to seek on the patient's behalf, the certificate set out in PART 2 below from the above mentioned medical practitioner.

I agree that the certificate should be returned to Sandwell MBC.

Signature of Patients Representative	
Date	/ /

PART 2 – Medical Practitioner's Authorisation

TO BE COMPLETED BY REGISTERED MEDICAL PRACTITIONER**Definition of Severe Mental Impairment for Council Tax reduction**

For Council Tax purposes a person is considered severely mentally impaired if he/she has severe impairment of intelligence and social functioning; however caused, which appears to be permanent. He/she must hold a certificate provided by a registered medical practitioner which confirms their condition.

Please provide the information requested overleaf along with an accompanying registered medical practitioner stamp to authenticate the certificate. If no stamp is available please provide the information on the surgery's/hospitals official letter head.

Name of Patient	
Patient's Address	

I certify that in my opinion the person named above is suffering from a severe mental impairment for Council Tax purposes as defined above and was first diagnosed on:

Date condition first diagnosed	/ /
Doctor's Status i.e. GP, consultant etc.	
Doctor's Full Name	
Doctors Hospital/Surgery Address	
Registered medical practitioner stamp	
Date	/ /