Application for Council Tax Discount for Severe Mental Impairment

PETERBOROUGH CITY COUNCIL

Shared Transactional Services

Town Hall

Peterborough

PE1 1HQ

Applicant's name: ……

Address:……

Account Ref (if known): **5**……

This form should be completed by the applicant or a person who is entitled to act on behalf of the applicant. Please complete all relevant sections in Part 1 of this form in **BLOCK CAPITALS** and arrange for the appropriate Medical Practitioner to complete Part 2. When all sections of the form have been completed the form should be returned to *Peterborough City Council, Shared Transactional Services, Town Hall, Peterborough, PE1 1HQ*, together with evidence of entitlement to the appropriate benefit mentioned in Part 1 of the form (such as a letter of entitlement). If you would like assistance with the completion of this form please contact the Local Tax team on 01733 452258 or email *local.taxation@peterborough.gov.uk*

PART 1 – To be completed by the applicant or the person acting on behalf of the applicant

1. Declaration of Benefit Entitlement (please provide evidence) (Please tick all relevant boxes)

a. Employment and Support Allowance ☐

b. Attendance Allowance ☐

c. Severe Disablement Allowance ☐

d. Constant Attendance Allowance ☐

e. Incapacity Benefit ☐

f. The disability element of Working Tax Credit ☐

g. Income Support which includes a disability premium ☐
(this includes anyone whose partner has a disability premium for them included in their income based Job Seekers Allowance)

h. DLA care component at the middle or higher rate OR PIP ☐

i. Universal Credit with a limited capability for work element ☐

2. Doctor's Name:

3. Doctor's Practice/Hospital Name:

4. Number of adult residents in property

5. Full Postal Address Doctors Practice or Hospital:

Postcode:

As the i) authorised representative of the applicant / ii) applicant (delete as appropriate) I declare that the statements and information provided in support of this application are, to the best of my knowledge, correct.

Signature **Date**

Full Name (Please Print)

Relationship to the Applicant (if applicable):

PART 2 – To be completed by the Registered Medical Practitioner

Medical Practice Name and Address (only if different to the details provided in Part 1)

Postcode

Please Insert Surgery Stamp Here

Please provide the effective date that the impairment commenced:

I certify that in my opinion the applicant named above is/is not suffering from a severe impairment of intelligence and social functioning which appears to be permanent.

Signature **Date**

Full Name (Please Print)

Doctors Status (e.g. GP, Consultant etc)

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For more information then please see our privacy notice on who we may work with and how we may use your data. It can be viewed online at https://www.peterborough.gov.uk/council/council-data/corporate-privacy-notice/ or you can contact us to request a paper copy.