COUNCIL TAX EXEMPTION APPLICATION FORM
Persons with severe mental impairment

When completing this form please make sure your address and reference number are clearly written

Council Tax Ref.: _____________________
Liable Party Name: ___________________________________
Property Address: ________________________________________________
Post Code: ____________

You may be granted an exemption from your Council Tax Bill if one or more of the residents in your home is severely mentally impaired and meets certain other conditions. In order that we can fully consider your application, please complete this form and return it to the address above.

1. Name of person for whom this claim is being made

__________________________________________

2. Name and address of the mentally impaired person’s doctor or registered medical practitioner

__________________________________________

__________________________________________

__________________________________________

__________________________________________

3. Number of adult residents in property ________

4. PLEASE TICK THE BOX ALONGSIDE THE BENEFIT WHICH THE APPLICANT RECEIVES

☐ Incapacity benefit
☐ Attendance allowance
☐ Severe disablement allowance
☐ Care component of a disability living allowance (which must be payable at either the highest or middle rate)
☐ Increase in disablement pension (attendance needed)
☐ A disability working allowance
☐ Unemployability supplement
☐ Constant attendance allowance
☐ Unemployability allowance
☐ Income support which includes a disability premium
☐ Unemployability allowance
☐ Income support which includes a disability premium
☐ Employment and Support Allowance

WE NEED TO SEE EVIDENCE OF THE BENEFIT OR ALLOWANCE YOU RECEIVE. IF YOU ARE PAID HOUSING BENEFIT OR COUNCIL TAX REDUCTION WE CAN CHECK BENEFIT RECORDS.

5. I confirm that the information given is correct to the best of my knowledge.
I understand that I maybe liable to a fine or prosecution for knowingly providing false information.
I understand that I must notify the Council Tax Office within 21 days of changes in circumstances.

THE LIABLE PERSON RESPONSIBLE FOR PAYING THE COUNCIL TAX OR AN AUTHORISED REPRESENTATIVE MUST COMPLETE AND SIGN THE FORM

Please print the name of the liable person:

First name: ___________________________ Signed: ___________________________

Surname: ___________________________ Date: ___________________________

Daytime Telephone No: ___________________________

If you have any queries please contact the Council Tax Section on 020 8356 3154 or email { HYPERLINK "mailto:council.tax@hackney.gov.uk" }
Severely Mentally Impaired
Council Tax Discount / Exemption application

Council Tax Ref: ____________________
Name of person for whom this claim is being made: ____________________
Property Address: ____________________________________________________

Post Code: _______________

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PLEASE ASK YOUR DOCTOR OR MEDICAL PRACTITIONER TO COMPLETE THIS PART

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<thead>
<tr>
<th>Please mark as appropriate</th>
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<tbody>
<tr>
<td></td>
<td>I certify that in my opinion the above person is not suffering from a severe mental impairment, for the purpose of the Local Government Finance Act 1992.</td>
</tr>
<tr>
<td></td>
<td>I certify that in my opinion the above person is suffering from a severe mental impairment, for the purpose of the Local Government Finance Act 1992.</td>
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<tr>
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<td>Date impairment started ____________________</td>
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A person is defined as suffering from severe mental impairment if he/ she has a severe impairment of intelligence and social functioning (however caused) which appears to be permanent. Please note that your opinion must be solely based on this definition.

Additional information in support of this claim-

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

Doctor or Medical Practitioner’s name: ____________________
Signature: ______________________________________________________________________
Date: ____________________ Doctor’s stamp

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