

Account Ref:

SECTION 1 – DETAILS OF THE PERSON WHO IS SEVERELY MENTALLY IMPAIRED

Surname		
Forename(s)		
Date of birth		
Date discount disregard required from		
Entitlement	Please ✓	
(a) Short-term or Long-term Incapacity Benefit/ESA (on the grounds of illness or disability)		
(b) Attendance Allowance		
(c) Severe Disablement Allowance		
(d) Unemployment supplement		
(e) The middle or higher rate care component of Disability Living Allowance		
(f) Increase in Disablement Pension where constant attendance is needed		
(g) Disability element of Working Tax Credit		
(h) Constant Attendance Allowance payable under the Industrial Injuries or War Pension schemes		
i) Unemployability Allowance payable under the industrial injuries or war Pension schemes		
(j) Income Support which includes a disability premium on grounds which include incapacity for work		
(k) Retirement Pension where the person concerned would have qualified for one of the above except that they are over pensionable age		
(l) Universal Credit (limited capability for work must be included)		
(m) Standard or enhanced rate of the daily living component of PIP.		

PLEASE GIVE THE DATE THE ALLOWANCE COMMENCED

SECTION 2 – HOUSEHOLD DETAILS

Number of people aged 18 or over resident in the applicant's property <input type="text"/>	Number of people aged 16 or 17 resident in the applicant's property <input type="text"/> Name(s)..... Date(s) of birth.....
---	--

PLEASE DO NOT FORGET TO ENCLOSE PROOF OF THE RELEVANT BENEFIT/PENSION/ALLOWANCE

SECTION 3 – DECLARATION AND SIGNATURE

I declare that the information given on this form is complete and accurate to the best of my knowledge.

REMEMBER, if you give false information you may be prosecuted.

SignatureDate

Full Name (BLOCK CAPITALS)

Telephone.....Email.....

Please note: Information will only be kept in accordance with the General Data Protection Regulation and the Data Protection Act 2018. Mid Sussex District Council will not supply information to any other organisation or individual except to the extent permitted by law in carrying out any of its functions. Please refer to our privacy notice on our website at <https://www.midsussex.gov.uk/about-us/privacy-notice> for further details.

If you are not the registered Council Taxpayer, please enclose a signed letter of authority or copy of the Power of Attorney to confirm if you are authorised to act on their behalf.

Please return this form to:

Mid Sussex District Council Revenues & Benefits, Oaklands Road, Haywards Heath, West Sussex, RH16 1SS

Email contact for the authority should be addressed to revenue@midsussex.gov.uk

COUNCIL TAX DISCOUNT - SEVERELY MENTALLY IMPAIRED

Property Address:	Date of Issue:
	Account Reference:
	Property Reference:
	To be returned within 21 days

Please complete part 1 of this form and then forward to the Medical Practitioner to complete Part 2.

PART 1 - AUTHORISATION OF HEAD OF REVENUES & BENEFITS

Name of applicant:

Applicant's address:.....

I authorise you to seek, on the applicant's behalf, a certificate from the following registered medical practitioner*

Doctor's name:

Doctor's surgery (or hospital):

Address of surgery (or hospital):

I agree that the Medical Practitioner should return this certificate direct to the Head of Revenues and Benefits if I am unable to do so myself.

Signature of person acting for the applicant:

Relationship to applicant:.....

Address:

Telephone number.....Date:

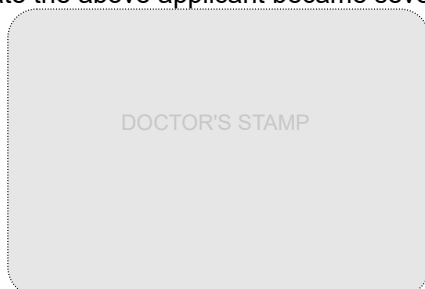
**This will normally be the applicant's General Practitioner. Any certificate issued will be for use ONLY in applying for a disregard for Council Tax discount purposes.*

PART 2 - TO BE COMPLETED BY A REGISTERED MEDICAL PRACTITIONER

The definition of severely mentally impaired, under the 1992 Local Government Finance Act, is as follows: 'A person is severely mentally impaired if he/she has a severe impairment of intelligence and social functioning (however caused) which appears to be permanent'. Any medical certificate for Council Tax purposes must be based on this definition and not on any other medical view of mental impairment.

I certify that in my opinion, the applicant named above is/is not (please delete as applicable) suffering from severe mental impairment for the purposes of the Local Government Finance Act 1992.

Date the above applicant became severely mentally impaired:



Doctor's signature:

Doctor's full name
BLOCK CAPITALS):

Doctor's status:

Date: