

**CLAIM FORM FOR A SEVERE MENTAL IMPAIRMENT DISCOUNT****BILLING REFERENCE (IF KNOWN) :**

Full Name of the Severely Mentally Impaired Person :

Address of Property:

Post Code:

Email Address :

Date of Birth:

Daytime Tel No.

Mobile Tel No.

**Please tick which qualifying benefit is in payment together with the effective date**

- |   |                          |         |                      |
|---|--------------------------|---------|----------------------|
| 1. Incapacity Benefit or was until reached pensionable age  | <input type="checkbox"/> | As from | <input type="text"/> |
| 2. Attendance Allowance or Constant Attendance Allowance  | <input type="checkbox"/> | As from | <input type="text"/> |
| 3. Severe Disablement Allowance   | <input type="checkbox"/> | As from | <input type="text"/> |
| 4. Higher or middle rate of the care component of the Disability Living Allowance                 | <input type="checkbox"/> | As from | <input type="text"/> |
| 5. An increase in the rate of disablement pension   | <input type="checkbox"/> | As from | <input type="text"/> |
| 6. Disability working allowance   | <input type="checkbox"/> | As from | <input type="text"/> |
| 7. Unemployability allowance payable under the industrial injuries or war pension scheme          | <input type="checkbox"/> | As from | <input type="text"/> |
| 8. Income Support or JSA (income based) where the applicable amount includes a Disability Premium | <input type="checkbox"/> | As from | <input type="text"/> |

**Please provide evidence of allowance (ie award letter) and send with the completed application for.**

**AUTHORISATION**

I declare that the information given is to the best of my knowledge, true and accurate. Furthermore, permission is given for the Council to approach the Medical Practitioner(s) named, in order to verify the grounds for disregarding the person shown.

Doctor's Name:

Doctor's surgery/Hospital Address:

Post Code:

Signature of person acting on applicant's behalf:

Date:

Full Name:

Relationship to Applicant:

Address:

Post Code:

Contact Telephone Number:

**TO BE COMPLETED BY A REGISTERED MEDICAL PRACTITIONER**

Doctors Surgery/Hospital Address (if different from above):

Post Code:

I certify that in my opinion the applicant named overleaf (please tick)  
suffering from severe mental impairment.

Is

Is Not

For the purpose of the Local Government Finance Act 1992, a person is severely mentally impaired if he/she has a severe mental impairment of intelligence and social functioning (however named) which appears to be permanent. (For advise please refer to the advice issued by the Department of Health about certificates of severe mental impairment.

Doctors Signature:

Doctor's Full Name:

Doctor's Status:

Date:

Payment of Council Tax must be made as shown on your bill until this application has been dealt with and you have been officially notified.

Please return to: Revenue Services, Town Hall, Alcester Street, Redditch, Worcs. B98 8AH