COUNCIL TAX
APPLICATION FOR DISREGARD
THE SEVERELY MENTALLY IMPAIRED

Name & address

Please complete the details below so your application can be given further consideration.

Name of person who is severely mentally impaired	

For the purposes of the above disregard the person concerned must be entitled of one or more of the following benefits. Please tick which benefit you receive.

A. Incapacity Benefit under section 30a of the Social Security (Contributions & Benefits) Act 1992. Employment & Support Allowance		**H.** Constant Attendance Allowance	
B. Attendance Allowance		**I.** Unemployability Allowance	
C. Severe Disablement Allowance		**J.** Income Support with a Disability Premium	
D. Disability Living Allowance middle or high rate (Care Component)		**K.** Incapacity Benefit under sections 40 & 41 of the Social Security (Contribution & Benefits) act 1992	
E. Disablement Pension		**L.** The standard or enhanced rate of the daily living component of the Personal Independence Payment	
F. Disability Working Allowance		**M.** armed forces independence payment under the Armed Forces and Reserve Forces(Compensation Scheme) Order 2011	
G. Unemployment Supplement		**N.** An increased rate of Universal Credit due to a limited capability for work or limited capability for work and work-related activity	

Whichever of the above benefits you tick please forward documentary proof that you are entitled to it. For example, a letter from the DWP or Benefits Agency showing your entitlement. It is not advisable to send payment books through the post. PLEASE NOTE THAT A DISREGARD CANNOT BE AWARDED WITHOUT THIS PROOF.

The person completing the application should sign below.

Name ___________________________ Signature ____________________________

Date ____________

Halton Borough Council, Council Tax, PO Box 223, Widnes, WA8 2DA
Telephone 0151 511 7771. E-mail council.tax@halton.gov.uk website www.halton.gov.uk

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THE SEVERELY MENTALLY IMPAIRED

Name & address

Under the Local Government Finance Act 1992, I need to approach the claimant's Doctor to obtain confirmation that he or she is severely mentally impaired.

I would be obliged if you could complete the authorisation below allowing me to approach the Doctor.

AUTHORISATION TO APPROACH CLAIMANT'S DOCTOR

I agree to the Revenues Manager approaching the claimant's Doctor for the purpose of obtaining a certificate confirming that,

Name ____

Address ____

Is severely mentally impaired under the provisions of the Local Government Finance Act 1992.

DOCTOR'S NAME ______________________________________

ADDRESS OF PRACTICE ______________________________________

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SIGNATURE ______________________________

DATE ______________________________

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