

date:

your reference:



PO Box 8  
Spalding  
PE11 2XQ

# Application for a saving on the council tax because of severe mental impairment

## Part 1 – About the person with severe mental impairment

1 Please tell us their full name:

2 Please tell us their date of birth:  
(for example, 01/03/1935)

3 Please tell us where they live:

.....  
.....

4 Please tell us how many people aged 18 or more live at the address given in question 3.

Now complete part 2 and part 3 overleaf

**Part 2 – About the benefit(s) received by the person named in part 1.**

**1 Please answer by ticking ( ✓ ) the boxes that apply.**

- Incapacity Benefit
- Attendance Allowance
- Severe Disablement Allowance
- Disability Living Allowance for Care – Middle or High rate
- Increased rate of Disablement Pension
- Working Tax Credit (with disabled person element)  
(formerly known as Disability Working Allowance and Disabled Person Tax Credit)
- Unemployability supplement paid as an increase to Disablement Benefit
- Unemployability supplement paid with War Disablement Benefit
- Constant Attendance Allowance
- Income Support which includes a disability premium (from 1 April 1994)
- Incapacity Benefit paid through special provisions for widows and widowers

**2 Please tell us when it was first paid  
AND send us proof of this date.**

DD / MM / YYYY

(If you do not have this information the Department of Works and Pensions or the Inland Revenue for Tax Credits, may be able to provide you with a letter confirming this).

**Signed:**

**Date:**

DD / MM / YYYY

**Full Name  
(Please PRINT)**



**(optional)**

**Part 3 – Permission to ask for information**

I give permission for South Holland District Council to ask the Doctor named below to complete the certificate in part 4. I am happy for the certificate to be returned to the Council with a copy for me.

**Person's name who saving has been applied for:**

**Their address:**

.....  
.....

**Doctor's name:**

**Doctor's address:**

.....  
.....

**Signature of person Acting for the above named :**

**Full Name (Please PRINT):**

**Please state your relationship to the above named:**

**Please give your address:**

.....  
.....

This form should now be returned to Council Tax Billing Section, Benefits and Revenues Team, South Holland District Council, Po Box 8, Priory Road, Spalding, PE11 2XQ

## Part 4 – Certificate for completion by the doctor

**This section is for completion by the doctor or registered medical practitioner named in part 3r**

Please tick ( ✓ ) the statement below which applies to the person named in part 3 overleaf.

I certify that in my opinion the person named in part 3 is:

Suffering from severe mental impairment and has been since

DD / MM / YYYY

Or

Not suffering from severe mental impairment

Doctor's signature:

Office stamp of Health Centre/Surgery

Doctor's full name:

Date:

DD / MM / YYYY

**To the Doctor:** Please return the top copy of this form with one of the copies in the postage paid envelope provided. We will forward the copy onto the applicant. The third copy can be kept for your records.

Return to :

Council Tax Billing Section  
Benefits and Revenues Team  
South Holland District Council  
Po Box 8  
Priory Road  
Spalding  
PE11 2XQ