

# Council Tax Exemption/Discount: Severely Mentally Impaired

Anyone who is medically certified as being Severely Mentally Impaired (SMI) may be eligible for a Council Tax exemption or discount. This means that the person will have a severe impairment of their intellectual and social functioning that appears to be permanent.

To be eligible, the person must be diagnosed as SMI by a doctor **and** must also be entitled to one of the benefits listed on this form.

Conditions that can lead to severe mental impairment, severe cognitive impairment or mental ill health include Alzheimer’s disease and other forms of dementia, Parkinson’s disease, severe learning difficulties or a stroke, but many others may apply. Having one of these conditions does not in itself mean that a person will be diagnosed as SMI by a doctor.

Council Tax Exemption/Discount:

- If you have been diagnosed as SMI by a doctor and you are living alone or only with others who are SMI, you will be exempt from paying Council Tax.
- If you have been diagnosed as SMI by a doctor and you live with one adult who is eligible to pay council tax, your household will receive a 25% discount.
- If you have been diagnosed as SMI by a doctor and you live with 2 or more adults who are eligible to pay council tax there will be no discount.

## Application form for Exemption/Discount

### PART A: Personal information

Full name of person applying to be disregarded:

National Insurance Number:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Date of Birth:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Address:

<p>Postcode:</p>		<p>Telephone Number:</p>
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Total number of adults (**residents over the age of 18**) living at this address:

## PART B: Declaration of benefit entitlement

A person may only be exempt or disregarded on the grounds of being SMI if they are entitled to one of the following benefits.

**If you are receiving or entitled to any of the benefits listed below, please provide evidence, such as a copy of the award letter or payment document.**

Please tick the relevant box(es):	When were the benefit(s) applicable from?								
<input type="checkbox"/> Incapacity Benefit	<table border="1"> <tr> <td>D</td><td>D</td> <td>M</td><td>M</td> <td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y		
<input type="checkbox"/> Attendance Allowance	<table border="1"> <tr> <td>D</td><td>D</td> <td>M</td><td>M</td> <td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y		
<input type="checkbox"/> Severe Disablement Allowance	<table border="1"> <tr> <td>D</td><td>D</td> <td>M</td><td>M</td> <td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y		
<input type="checkbox"/> Disability Living Allowance (higher or middle rate care component)	<table border="1"> <tr> <td>D</td><td>D</td> <td>M</td><td>M</td> <td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y		
<input type="checkbox"/> An increase in disablement pension (as constant attendance is needed)	<table border="1"> <tr> <td>D</td><td>D</td> <td>M</td><td>M</td> <td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y		
<input type="checkbox"/> Disability Working Allowance	<table border="1"> <tr> <td>D</td><td>D</td> <td>M</td><td>M</td> <td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y		
<input type="checkbox"/> Income support (which includes a disability premium)	<table border="1"> <tr> <td>D</td><td>D</td> <td>M</td><td>M</td> <td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y		
<input type="checkbox"/> Unemployability Supplement or Allowance	<table border="1"> <tr> <td>D</td><td>D</td> <td>M</td><td>M</td> <td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y		
<input type="checkbox"/> Constant Attendance Allowance	<table border="1"> <tr> <td>D</td><td>D</td> <td>M</td><td>M</td> <td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y		
<input type="checkbox"/> Personal Independence Payment (standard or enhanced rate)	<table border="1"> <tr> <td>D</td><td>D</td> <td>M</td><td>M</td> <td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y		
<input type="checkbox"/> Armed Forces Independence Payment	<table border="1"> <tr> <td>D</td><td>D</td> <td>M</td><td>M</td> <td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y		
<input type="checkbox"/> Universal Credit (in circumstances where a person has limited capability for work and/or work related activity)	<table border="1"> <tr> <td>D</td><td>D</td> <td>M</td><td>M</td> <td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y		

Continue in Part E if needed.

## PART C: Doctor or Medical Practitioner's declaration

(to be completed by the Doctor/Medical Practitioner)

Name of doctor/medical practitioner:

Contact details of surgery/hospital

Address:

Postcode:	Telephone Number:
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A person is regarded as severely mentally impaired if they have a severe impairment of intelligence and social functioning (however caused) which appears to be permanent. *Local Government Finance Act 1992 (Schedule 1, Paragraph 2)*.

I can confirm the person named in **PART A** is SMI as defined above. **(Please tick box)** Yes  No

A Council Tax exemption/discount may be backdated to the point of diagnosis. For the purposes of this form, please enter the first point at which you would consider the patient to be SMI.

Date of Diagnosis:

D	D	M	M	Y	Y	Y	Y
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Doctor's signature:

Date:

D	D	M	M	Y	Y	Y	Y
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Official Stamp:

**Note: GPs should not charge for the diagnosis and/or completion of this form.**

*British Medical Association, The National Health Service (General Medical Services Contracts) Regulations 2004 (Regulation 21(1) and Schedule 4).*

## PART D: Applicant's declaration

I accept responsibility for the information given in this form, and declare that it is true and accurate to the best of my knowledge and belief. I authorise the council to make any enquiries it considers necessary to verify the details of this claim.

Applicant's signature:

Date:

D	D	M	M	Y	Y	Y	Y
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If you are completing the form on behalf of the applicant, what is your relationship to them?

Name of person acting on applicant's behalf:

Address of person acting on applicant's behalf:

Postcode:		Telephone Number:
E-mail:		

Signature of person acting on applicant's behalf:

Date:

D	D	M	M	Y	Y	Y	Y
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Your application will be processed in accordance with the General Data Protection Regulation (GDPR) 2018. To view further information about GDPR, please visit your local council's website and look at their published privacy notice. You should also notify the council of any change in circumstances.

When you have completed this form and it has been signed by a medical practitioner, please post to your local authorities council tax office. You can find the address at [gov.wales/local-authority-council-tax-contacts](http://gov.wales/local-authority-council-tax-contacts).

## PART E: Further Information

Please provide any additional information in support of your application.