Revenues & Welfare Support
Civic Centre, Arnot Hill Park
Arnold, Nottingham, NG5 6LU

Email: revenues@gedling.gov.uk
Web: www.gedling.gov.uk
Direct Line: 0115 901 3950
Contact Centre: 0115 901 3901
Our ref:
Your ref:
Date:

$$$$$$$$

LOCAL GOVERNMENT FINANCE ACT 1992
THE COUNCIL TAX (DISCOUNT DISREGARDS) ORDER 1992

Dear

In order to apply for a discount disregard with regards to a person who is severely mentally impaired, please complete each section in BLOCK CAPITALS and return the form to Revenues & Welfare Support at the above address.

Yours sincerely

Duncan Adamson
Service Manager – Revenues & Welfare Support

Section 1 (to be completed by the applicant or applicants aide)

Applicants Name:	
Address:	
Telephone Number:	

If you are acting on behalf of the applicant, please complete

Full Name Of Person Acting On Applicants Behalf:	
Address:	
Telephone Number:	

Declaration Of Benefit Entitlements

Benefit	Entitlement Date
Incapacity Benefit Under Sections 30A, 40 Or 41	
Attendance Allowance or Employment and Support Allowance	
Severe Disablement Allowance	
Care Component Of A Disability Living Allowance (High/Middle Rate)	
Personal Independence Payments (Standard or Enhanced Rate)	
An Increase In The Rate Of Disablement Pension	
Disability Working Allowance	
An Unemployability Supplement or Allowance	
A Constant Attendance Allowance	
Income Support Including A Disability Premium	
Entitled To One Of The Above But Of Pensionable Age	
Partner In Receipt Of Job Seekers Allowance And Relevant Premium	

Please enclose proof of benefit entitlement

Authorisation of Gedling Borough Council

I authorise Gedling Borough Council to seek, on the applicants' behalf, the certificate in Section 2 below from the following medical practitioner (this will normally be the applicant's general practitioner). I agree that the certificate should be returned to you as the Billing Authority.

Signature:		**Date:**	
Name And Address Of Doctor:			

Section 2 (to be completed by the registered medical practitioner named above)

I certify that in my opinion the Applicant named in Section 1 above:

(Please select one of the following options and provide the relevant date)

• **IS NOT** suffering from a severe mental impairment	
• **IS** suffering from a severe mental impairment and has been so **since** ..... (enter relevant date)	

Doctors Full Name:			
Doctors Status:			
Doctors Signature:		**Date:**	