Severely Mentally Impaired (SMI) Application Form

SDC/2223/AUG26

Stratford-on-Avon District Council
Revenues Department, Elizabeth House, Church Street, Stratford-upon-Avon. CV37 6HX
Email: revenues@stratford-dc.gov.uk Website: www.stratford.gov.uk Telephone: 01789 260990

If you find the text in this form difficult to read we may be able to supply it in a format better suited to your needs.

People over the age of 18 who have been medically certified as having a severe and permanent condition that significantly affects how they function in daily life may be eligible for a Council Tax discount or exemption.

Conditions include (but are not limited to):

- Dementia
- Alzheimer's disease
- Severe Learning Disabilities
- Long-term effects following a stroke

A doctor or medical practitioner must certify the diagnosis to qualify.

How does someone qualify?

To qualify you must: provide certification from a doctor or medical practitioner and be receiving, or entitled to receive, one of the qualifying benefits listed in Part B.

How much discount can you get if the application is successful?

If the property is only occupied by persons over 18 who have successfully been awarded the SMI discount/exemption, the household would be exempt from Council Tax.

DATA PROTECTION

Privacy notice: We will use your personal data to assess and administer your Council Tax. We may share your information with other departments in the substantial public interest and in the exercise of our official authority. Your data will be held in accordance with our Retention and Destruction Policy. For further information, please visit www.stratford.gov.uk/privacy or call 01789 267575.

PART A PERSONAL DETAILS

Applicant's Full Name (Person with Severe Mental Impairment):	
If applying on behalf of someone, please tell us your name:	
If applying on behalf of someone, please provide a contact number or email address in case of enquiries:	
If applying on behalf of someone, please state your relationship to that person:	
Applicants Address:	
Applicant's Postcode:	
How many people aged 18 years or over live at this address?	
Council Tax Account Number:	
Applicant Telephone Number:	
Applicant Email Address:	

PART B BENEFIT ENTITLEMENT (Tick all that apply)

Please provide evidence of the date the benefit was first received, such as a copy of the award letter.

- ☐ Attendance Allowance
- ☐ Severe Disablement Allowance
- ☐ Disability Living Allowance (middle or high-rate care component)
- ☐ Personal Independence Payment (standard or enhanced daily living component)
- ☐ Armed Forces Independence Payment
- ☐ Disabled Persons Tax Credit
- ☐ Constant Attendance Allowance
- ☐ Unemployability Supplement
- ☐ Income Support which includes a disability premium
- ☐ Unemployability Allowance
- ☐ Employment and Support Allowance
- ☐ Universal Credit which includes an element related to limited capability for work or work-related activity

PART D DECLARATION

I declare that the information on this form is correct and completed to the best of my knowledge. I agree that the Council may make any enquiries to check information. I agree to inform the Council of any change in circumstances which could affect this application. I understand that any false declaration given by me can result in prosecution under the Fraud Act 2006.

Signature of applicant/on behalf of applicant: _____

RETURNING THIS FORM

Once Parts A, B, C (Doctor's Certificate) and D of this form are complete, please email to **revenues@stratford-dc.gov.uk**

PLEASE ENSURE THAT YOU ATTACH A COPY OF THE EVIDENCE CONFIRMING ENTITLEMENT TO A QUALIFYING BENEFIT.

PLEASE ENSURE PART C (DOCTOR'S CERTIFICATE) IS SUBMITTED WITH THIS FORM.

Alternatively, the completed form and copies of evidence documents may be posted or delivered in person to:

Revenues Department
Stratford-on-Avon District Council
Elizabeth House
Church Street
Stratford-upon-Avon
CV37 6HX

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Doctor's Certificate

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PLEASE PASS THIS PAGE TO YOUR/THE APPLICANT'S DOCTOR OR MEDICAL PRACTIONER TO COMPLETE

PART C DOCTOR'S CERTIFICATE (To be completed by the Doctor/Medical Practitioner)

A person is severely mentally impaired if they have a severe impairment of intelligence and social functioning, however caused, which appears to be permanent. Please refer to the Local Government Finance Act 1992 Schedule 1.

I certify in my opinion the person named below:

Title:

First Name:

Surname:

(tick one):

☐ **IS** suffering from severe mental impairment

☐ **IS NOT** suffering from severe mental impairment

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 have a severe mental impairment.

Date (dd/mm/yyyy):

Doctor's name (BLOCK CAPITALS):

Doctor's Signature:

Date (dd/mm/yyyy):

Doctor's surgery address/address stamp:

Doctor's Surgery Postcode:

Please note that in accordance with the Department of Health advice letter of March 1993 PL/CO(93) 1, and The National Health Service (General Medical Services) Amendment Regulations 1993, **no fee should be charged for this certification.**

PLEASE RETURN THIS PAGE TO THE APPLICANT FOR SUBMISSION. ALL SECTIONS OF THE FORM MUST BE FULLY COMPLETED.