

SOUTH GLOUCESTERSHIRE COUNCIL

Chief Executive and Corporate Resources Department, Revenue Services,

P O Box 1953, Bristol, BS37 0DB

www.southglos.gov.uk

TEL: 01454 868003 FAX: 01454 868420

COUNCIL TAX DISCOUNT / EXEMPTION APPLICATION LONG TERM PATIENTS IN HOSPITALS OR HOMES

FORM

1

The Council Tax regulations provide for a discount to be granted if there are less than two adult residents in a dwelling. In counting the number of adults any person who is a long-term patient in a hospital, nursing home or residential care home may be disregarded. In addition to this, any property left unoccupied by a taxpayer whose main residence is as above may also be exempt from any charge thereafter. If a discount or exemption is to be claimed the applicant should complete the form below in BLOCK CAPITALS and return it as soon as possible.

Before completing this form it is important that you read the notes overleaf.

SECTION 1

| | |
|---|-------|
| APPLICANT'S NAME (must be a person liable to pay the Council Tax on the dwelling) | |
| BILLING NUMBER | ctrel |
| ADDRESS | |
| | |
| DAYTIME TELEPHONE NUMBER | |

SECTION 2

| | |
|---|--|
| NUMBER OF RESIDENT ADULTS LIVING IN THE PROPERTY INCLUDING THE PERSON NAMED BELOW (i.e. persons aged over 18) | |
|---|--|

SECTION 3 - PATIENT IN HOSPITAL/HOME (must have formerly resided in the dwelling for which a discount/ exemption is claimed)

| | |
|------|--|
| NAME | |
|------|--|

| |
|--|
| Address(s) of hospital(s)/home(s) where the person to be discounted/exempted has been continually resident |
|--|

| | | | |
|----|-----------|---|---|
| 1) | DATE FROM | / | / |
| | DATE TO | / | / |
| 2) | DATE FROM | / | / |
| | DATE TO | / | / |
| 3) | DATE FROM | / | / |
| | DATE TO | / | / |

| | | | | |
|---|-----|--|----|--|
| Does this person intend to re-occupy the property on a permanent basis? | YES | | NO | |
| If YES please state anticipated date of return | | | | |

SECTION 4 - DECLARATION BY APPLICANT

I declare that the information given on this form is true and accurate to the best of my knowledge and belief.

| | |
|------------------------|------|
| SIGNATURE OF APPLICANT | DATE |
|------------------------|------|

| |
|---|
| Relationship to person for whom discount is being claimed (if different from applicant) |
|---|

| |
|--|
| |
|--|

| |
|--|
| Address to which correspondence should be sent (if different from that on the front of the form) |
|--|

| | |
|----------|-----------|
| | |
| | |
| POSTCODE | TELEPHONE |

You must notify the Director of Corporate Resources immediately if you have any change in circumstances.

This form should be returned to the Council's offices at the address shown at the head of the application.

NOTES FOR APPLICANT

1. You do not have to complete this form unless you wish to claim a discount but if you provide false information you may be subject to a penalty of £70 and prosecution under the Theft Act 1978.
2. Any information provided will be treated in the strictest confidence but may be stored on computer and is therefore subject to the provisions of the Data Protection Act 1984.
3. A person who is resident in a hospital for less than **12 months** normally will not be considered to be a long-term patient for Council Tax