Falkirk Council
Corporate & Housing Services

Please return completed forms to:

Callendar Square Centre, Falkirk, FK1 1UJ

Name	
Address	
Postcode	

COUNCIL TAX RELIEF CLAIM FORM
RESIDENT IN CARE

A full Council tax Bill assumes that there are two adults (aged 18 or over) in a household. Some household members are disregarded for the purposes of Council Tax Discount

Resident In Care – Someone in hospital or residential care home with no intention to return to the property.

To work out if you are due a discount we look at the circumstances of all residents (see below) in a property. We then count all adults who are not disregarded.

If after doing the count all but one of the adults are disregarded a 25% discount is awarded. If all the residents are in care then an exemption is awarded

Resident – Someone aged over 18 years who has his or her **Sole or Main Residence** in the property.

Sole or Main Residence – Where a person is absent from the household, e.g working elsewhere, this person is associated with 2 properties. In these circumstances the Council must make a determination as to what that person's "sole or main residence". In the majority of these situations the person's main residence is the "family" home.

Please detail below anyone aged 17or over who is resident (see above) in your property.

Name	**Are they resident in care? (delete as appropriate)**	**Do they own the property?**	**Date of Birth (for 17 year olds)**
	Yes / No	Yes / No	
	Yes / No	Yes / No	
	Yes / No	Yes / No	
	Yes / No	Yes / No	
	Yes / No	Yes / No	
	Yes / No	Yes / No	

Declaration :

1. I have read and understood the contents of this form.
2. I confirm all the information given is a true and full statement.
3. I will notify Falkirk Council immediately if my circumstances change.

Signed _____ Date _____ Daytime Tel. Number (in case of query) _____

Now have the certificate on the reverse of this form completed by the Hospital/Care Home and return it to us.

Falkirk Council
Corporate & Housing Services

COUNCIL TAX : Resident in Care (HP)

To be completed by the Hospital or Residential Care Home

Re:		
Name of person resident in care:		
Home Address:		
From what date have they been resident in care?		
How long is this care likely to last?		
Where is this care being provided? (Address of Hospital or Residential Care Home)		
Were they in care prior to this date?	Yes	No
If Yes, where?		
And from what date?		
What date was the decision made that they would not be returning to their own home?		

Declaration:			
Signed		Hospital or Care Home Stamp	
Designation			
Date			