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Falkirk Council
Corporate & Housing Services

COUNCIL TAX RELIEF CLAIM FORM
Severely Mentally Impaired (SMI)

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

Severely Mentally Impaired (SMI) – Someone who has a permanent severe impairment of intelligence and social functioning, as defined by a medical practitioner. They must also be in receipt of one of the qualifying benefits detailed in section 1 overleaf.

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 Severely Mentally Impaired 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.

Your name:

Property Address:

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

Name	Are they SMI? (delete as appropriate)	Do they own the property?	Date of Birth (for 17 year olds)
_____	Yes / No	Yes /	_____
_____	Yes / No	Yes /	_____
_____	Yes / No	Yes /	_____
_____	Yes / No	Yes /	_____
_____	Yes / No	Yes /	_____

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 (Note Section 3 must be completed by a medical practioner) and return it by email to revenues1@falkirk.gov.uk or by post

Please help us by setting up ebilling	
Rather than posting out a paper Council Tax bill, we will email you a PDF bill instead.	
Please tick if you would like to help and do this :	
YOUR EMAIL ADDRESS:	

COUNCIL TAX

Severe Mental Impairment Certificate (SMI)

Section 1: Qualifying Benefit

Name:	

	Please
This person is entitled to Incapacity Benefit or Employment and Support Allowance	
Attendance Allowance	
Constant Attendance Allowance	
Severe Disablement Allowance	
Middle or High Care component of Disability Living Allowance	
Daily Living component of Personal Independence Payment	
War Pension or Industrial Injuries Benefit including Constant Attendance Allowance	
An Unemployment Supplement to Industrial Injuries Benefit	
An Unemployment element within Industrial Injuries Benefit or War Disablement Pension	
Income Support including a Disability Premium on the grounds of incapacity for work	
Disabled Persons Tax Credit	
Date Benefit Awarded From:	/

Please provide the award letter showing the date the benefit was first awarded from.

Section 2: About the Person Filling In This Form

Name	
Address	
Relationship to the person named in Section 1	
If the Council Tax correspondence should be issued via yourself, tick here	

Section 3: For Completion by a Registered Medical Practitioner

Local Government Finance Act (1992) - 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 confirm whether or not this individual meets each of the following criteria:

• They have a severe impairment of intelligence	Yes	No
• They have a severe impairment of social functioning	Yes	No
• Both of these appear to be permanent	Yes	No

UNLESS YOU CAN ANSWER YES TO EACH STATEMENT, I.E. IF ALL THREE CRITERIA ARE MET, PLEASE DO NOT COMPLETE THIS FORM ANY FURTHER.

In my opinion the person named in Section1 is/has been severely mentally impaired from	/ /
Doctors Name (Please Print)	
Surgery/Hospital Address	
Signature	
Date	/