Corporate and Community Services Department
Director: Caroline Innes
211 Main Street, Barrhead, Glasgow, G78 1YF
Phone: 0141 577 3002 Fax 0141 577 3255
Email: ctax@eastrenfrewshire.gov.uk
When calling please ask for: Customer Services
Our Ref: WEBFORM

Name:

Address:

COUNCIL TAX DISCOUNT

The Council Tax due on a property may be discounted to reflect the personal circumstances of the adult residents. Such a reduction will apply where less than two adults are resident in the property. For the purpose of the reduction adults who meet the under noted qualifying conditions shall be disregarded when counting the number of adults in the house.

If you want to apply for discount please provide the information requested overleaf, sign the declaration and return the form to the above address.

QUALIFYING CONDITIONS: LONG TERM PATIENT IN HOSPITAL/ RESIDENTIAL HOME

A person who has their sole or main residence in an NHS/ Armed Forces hospital or in a residential care home/ nursing home/private hospital/hostel where they receive care or treatment.

Please note – unless the Nursing Home/Hospital state that the person is in care permanently, a period of 13 weeks must have elapsed since the person went into care before any discount can be awarded.

Our Service Standards:	➢	***We will reply to all mail within 20 working days.***
	➢	***We will determine all requests for discounts/changes in circumstances and issue a revised bill within 20 working days.***
	➢	***We will update the customer's account within 2 working days of payment at a council office or within 2 working days of notification being received from the council's bankers or Girobank***
	➢	***We will ensure that all residents are notified within six weeks of a missed payment.***

DISCOUNT: LONG TERM PATIENT IN HOSPITAL / RESIDENTIAL HOME

SECTION 1 : TO BE COMPLETED BY A LIABLE PERSON

I apply for discount on the basis that

Name ……..
meets the qualifying conditions noted overleaf.

The date these circumstances took effect …… / …… / ……

The number of adults (including the above named) resident in the house at the above date is ☐

The number of adults (including the above named) usually resident in the house is ☐

SECTION 2 : TO BE COMPLETED BY HOSPITAL / HOME

I confirm that the above named person was admitted to this establishment on ……/……/……

Expected discharge date if known ……/……/……

Please can you confirm if the above named person is a permanent resident? **Yes/No**

Please confirm when they became a permanent resident if not the same as admission date
……/……/……

They receive the following care/treatment:

Establishment Stamp:

Signed ……..

Print Name ……..

Contact Telephone number ……

If your establishment does not have a stamp please enclose a Compliment Slip or sheet of Headed Paper

DECLARATION

I declare that the information on this form is true and complete and I authorise East Renfrewshire Council to verify the details.

I will notify within 21 days any change in circumstances which may affect my liability e.g. discount status no longer applies to the person named in Section 1, or the number of adults in the house increases.

I understand that failure to provide this information is an offence which may make me liable to an initial fine of £50 and £200 for each subsequent offence.

Signature of Liable Person …… Date …… / …… / ……

Daytime Tel Number: …… Email Address: ……
(You do not have to tell us these but it may help us deal with your discount application quicker)

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E-mail : ctax@eastrenfrewshire.gov.uk

Establishment Two

I confirm that the above named person was admitted to this establishment on ……/……/……

Expected discharge date if known ……/……/……

Please can you confirm if the above named person is a permanent resident? Yes/No

Please confirm when they became a permanent resident if not the same as admission date ……/……/……

They receive the following care/treatment:

Establishment Stamp:

Signed ……..

Print Name ……..

Contact Telephone number ……

If your establishment does not have a stamp please enclose a Compliment Slip or sheet of Headed Paper.

Establishment Three

I confirm that the above named person was admitted to this establishment on ……/……/……

Expected discharge date if known ……/……/……

Please can you confirm if the above named person is a permanent resident? Yes/No

Please confirm when they became a permanent resident if not the same as admission date ……/……/……

They receive the following care/treatment:

Establishment Stamp:

Signed ……..

Print Name ……..

Contact Telephone number ……

If your establishment does not have a stamp please enclose a Compliment Slip or sheet of Headed Paper.

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