

REF NO:

Name:

Correspondence Address:

Subject Address:

COUNCIL TAX PROPERTY EXEMPTION APPLICATION
RECEIVES PERSONAL CARE

Reference No:

In terms of Schedule 11 of the Local Government Finance Act 1992, and the Council Tax (Exempt Dwellings) Scotland Order 1992 (as amended), a dwelling house may be exempt from Council Tax (including the water & sewerage charge), if it falls within the category shown below. Depending on the circumstances, Exemption may be granted for an unlimited period.

Please supply the details requested, sign the declaration and return this form to the address shown below.

UNOCCUPIED HOUSE WHICH IS

1. Which when last occupied, was occupied by a person who receives personal care by reason of:
 - a. Old age;
 - b. Disablement;
 - c. Illness;
 - d. Past or present alcohol dependence;
 - e. Past or present drug dependence;
 - f. Past or present mental disorder;

I consider Exemption should apply from/...../..... to/...../.....

Please note that the liable person must be in care for a consecutive period of 13 weeks or more or be in permanent care before they will qualify for this exemption

I declare that the information on this form is true and complete and I authorise East Renfrewshire Council to verify the details. If Exempt status no longer applies to this property I undertake to notify East Renfrewshire Council within 21 days of this occurring.

I UNDERSTAND THAT FAILURE TO PROVIDE THIS INFORMATION IS AN OFFENCE WHICH MAY MAKE ME LIABLE FOR AN INITIAL FINE OF £50.00 AND £200.00 FOR EACH SUBSEQUENT OFFENCE. Furthermore, this information may be shared with other public bodies e.g. neighbouring Councils or other organisations, which handle public funds, for the purposes of preventing and detecting fraud.

PAYMENTS MUST CONTINUE PENDING THE OUTCOME OF YOUR APPLICATION

East Renfrewshire Council Offices, 211 Main Street, Barrhead, G78 1YF Telephone: 0141 577 3002 Fax: 0141 577 3255

E-mail : ctax@eastrenfrewshire.gov.uk

Our Service Standards:	<ul style="list-style-type: none"> > 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.
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EXEMPTION : LONG TERM IN HOSPITAL/RESIDENTIAL HOME

SECTION 1 : TO BE COMPLETED BY A LIABLE PERSON OR REPRESENTATIVE

1. I (liable person's name).....apply for exemption from Council Tax.

2. The number of adults (including the above named) usually resident in the house is:-

3. Name and address of current owner of property:

Name:

Address:

Signed

Date

Print Name

If you are not the liable person please state your relationship and supply a contact telephone number

Relationship

Tel No

The information in section two is required from each establishment where the above named person has been admitted. If there is more than one establishment please use page three.

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.*

EXEMPTION WILL NOT BE GRANTED UNLESS THE FORM HAS BEEN FULLY COMPLETED

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.*