

# Council Tax



[www.aberdeencity.gov.uk/services/council-tax](http://www.aberdeencity.gov.uk/services/council-tax)

Name .....

Current Address.....

.....

.....

Postcode .....

We may have to contact you for information, please provide:-

Council Tax Reference Number .....

Telephone Number.....

Mobile Number .....

Email Address .....

## Application for Hospital/Residential/Nursing Home Discount/Exemption

### Please read this form carefully

Discount or Exemption may be given on a Council Tax Account if a person is a patient in a **Hospital/Residential/Nursing Home**

The patient must meet the following conditions:

- Residence must be indefinite or permanent in a **Hospital/Residential/Nursing Home**

There are three parts to this form:

- Part 1 should be filled in by the **patient, relative or agent acting on behalf of the patient.**
- Part 2 should be filled in by the **Hospital/Residential/Nursing Home**
- Part 3 should be signed by the **liable person** (the person whom the Council Tax Account is sent) **or relative or agent acting on behalf of the patient.**

**A visit to your property may be undertaken.**

### PART 1 Patient details (to be filled in by the patient, relative/agent acting on behalf of the patient)

Patient's full name .....

Patient's date of birth .....

Is the patient's home address vacant?

Yes

No

Has the patient sold this property or terminated the lease since entering hospital?

Yes

No

If Yes, please give details .....

If the patient is not the owner of the property, please provide the following information:

Full name of property owner .....

Address of property owner .....

Email address of property owner .....

Please sign the authorisation below and hand this form to the **Hospital/Residential/Nursing Home** as soon as possible, so they can complete Part 2.

I authorise the **Hospital/Residential/Nursing Home** to give the information requested overleaf.

Signed .....

Date .....

(If you signed on behalf of the patient, please fill in the following details)

Your name and address: .....

Telephone Number: .....

Mobile Number:.....

Email address .....

What is your relationship to the patient: .....

**PART 2** Hospital/Residential/Nursing Home **details** (To be filled in by the **Hospital/Residential/Nursing Home**)

The person named overleaf has indicated that they are currently a patient in your **Hospital/Residential/Nursing Home**. Please answer the questions below and then return this form to the patient, relative or agent acting on behalf of the patient.

Name and address of person acting on behalf of the **Hospital/Residential/Nursing Home**:

.....  
.....

Date of admission: ..... Confirm if long-term patient: YES  NO

Long Term means the patient is not expected to return home or does not have a date when they are likely to return home.

Has the patient been transferred from another **Hospital/Residential/Nursing Home**? YES  NO

If yes, please give the date of admission .....

Name and address of the **Hospital/Residential/Nursing Home** .....

.....

Please print your name: .....

Please print your position: .....

Email address (to be used if further information is required) .....

OFFICIAL STAMP

If you do not have an official stamp please tick this box

Signed

Date

**Please ensure this form is stamped and returned to the patient.**

**Please read the following carefully and sign the declaration below.**

**Your data** - We collect and maintain information about you for Council Tax, Water and Waste Water purposes in line with the Local Government Finance Act 1992. We share information with the DWP, HMRC, Sheriff Officers and a variety of other organisations all as allowed by law. This information is used across the Council, to ensure that we keep your name and address details accurate and up to date.

**National Fraud Initiative** - We have a duty to protect the public funds we administer. We will use the information you provide on our forms to help prevent and detect fraud. We will also share this information, for these purposes, with other organisations responsible for auditing or administering public funds.

More information about how we use and manage your information is available on our website at: [www.aberdeencity.gov.uk/your-data/privacy-notices/your-data-council-tax](http://www.aberdeencity.gov.uk/your-data/privacy-notices/your-data-council-tax). This page also has links to further information about your rights, and who to contact if you have a complaint about how we use your data.

If you have difficulty with any part of this form or if you require further details, please telephone Customer Services on 03000 200 292 (visit the Contact Us page on our website for up to date opening hours).

**Part 3 Declaration (To be signed by the liable person)**

I declare that the information on this application form is true and correct. I undertake to inform Revenues and Benefits of any change in circumstances as soon as the change occurs.

Signature ..... Date .....

**Thank you for completing this form, please scan and email it to [counciltax@aberdeencity.gov.uk](mailto:counciltax@aberdeencity.gov.uk) or by mail to Revenues and Benefits, Aberdeen City Council, Business Hub 16, Marischal College, Broad Street, Aberdeen, AB10 1AB**