



Tendring

District Council

88-90 Pier Avenue
CLACTON ON SEA
Essex
CO15 1TN

Date:
My Ref:
Your Ref:
Please ask for: COUNCIL TAX
HELPLINE 01255 686822

FOR OFFICE USE ONLY
VAL BAND
ACC NO
OTHER

APPLICATION FOR COUNCIL TAX (REDUCTION FOR DISABILITIES)

PLEASE COMPLETE IN BLOCK CAPITAL LETTERS IN INK

1 NAME OF APPLICANT

2 NAME OF DISABLED PERSON
(If different from above)

FOR PROPERTIES THAT HAVE MORE THAN ONE DISABLED RESIDENT PLEASE SELECT ONE APPLICANT AND COMPLETE THE FORM USING HIS/HER DETAILS.

3 ADDRESS OF PROPERTY FOR
WHICH A REDUCTION IS
CLAIMED

TELEPHONE NO

(You do not have to give this information but it would help if there is a query relating to your application).

4 PLEASE STATE THE NATURE
OF THE DISABILITY

5 IT IS THE ADAPTATION TO THE HOME OR SPECIAL FACILITY THAT ATTRACTS THE RELIEF RATHER THAN THE DISABILITY ALONE. HOWEVER, THERE MUST BE A DISABLED PERSON RESIDENT IN THE PROPERTY. REDUCTIONS CAN ONLY BE AWARDED IF AT LEAST ONE OF THE SPECIAL FACILITIES LISTED BELOW IS PRESENT IN PROPERTY:-

(A) **A ROOM (OTHER THAN A KITCHEN, BATHROOM OR LAVATORY)**

THE ROOM MUST BE USED PREDOMINANTLY BY THE DISABLED PERSON TO MEET HIS/HER NEEDS.

WHICH ROOM IS IT?

PLEASE INDICATE THE USE TO WHICH THE DISABLED PERSON PUTS THE ROOM AND ADVISE WHETHER OTHER MEMBERS OF THE HOUSEHOLD USE IT.

Three empty rectangular boxes for text entry.

Please continue on a separate sheet if necessary

Tick Below

(B) A SECOND BATHROOM

THIS MUST BE ADDITIONAL AND REQUIRED FOR MEETING THE NEEDS OF THE DISABLED PERSON.

Tick Below

(C) A SECOND KITCHEN

THIS MUST BE ADDITIONAL AND REQUIRED FOR MEETING THE NEEDS OF THE DISABLED PERSON

Tick Below

(D) SUFFICIENT FLOOR SPACE INSIDE THE PROPERTY FOR WHEELCHAIR CIRCULATION

THIS WILL VALIDATE A CLAIM WHERE THE DISABLED PERSON IS WHEELCHAIR BOUND INSIDE THE HOME.

6 DATE THAT THE SPECIAL FACILITY WAS FIRST PROVIDED AT THIS ADDRESS

APPLICANTS DECLARATION

I declare that the information is correct and undertake to give immediate notification of any changes to the special facilities, or if the disabled person should cease to reside in the accommodation.

SIGNED DATE

THIS FORM SHOULD NOW BE SENT TO EITHER A DOCTOR, SOCIAL WORKER OR OCCUPATIONAL THERAPIST WHO WILL CONFIRM THAT THE SPECIAL FACILITIES INDICATED BY THE CLAIMANT ARE ESSENTIAL, FOR THE WELLBEING OF THE DISABLED PERSON.

MEDICAL DECLARATION

To the person certifying this form.

I certify, that in my opinion, the special facilities indicated on this application by the claimant are essential, for the wellbeing of the disabled person.

SIGNED DATE

ADDRESS [Three empty rectangular boxes for text entry]

*(DOCTOR/SOCIAL WORKER/OCCUPATION THERAPIST)

*Delete as appropriate