Aberdeenshire COUNCIL

Council Tax
Application for Hospital/ Residential / Nursing Home Exemption or Discount

Property no.

Name		Reference no.	
Address		Issue Date	DD / MM / YYYY
		Return by date	DD / MM / YYYY
Postcode			

Information

Exemption or Discount may be granted if a person is a patient in a hospital, residential or nursing home.

The patient must

- be resident in the hospital, residential or nursing home continuously, for more than 6 weeks; or
- their residence must be permanent.

Part 1 PATIENT DETAILS *(To be filled in by you or the person acting on your behalf)*

Full name

Date of Birth DD / MM / YYYY

Property Address

Postcode

Is the patient's home address unoccupied? Yes ☐ No ☐

If yes, please confirm the date the property was last occupied DD / MM / YYYY

If no, the number of adults (including the above) usually residing in the property is

Please provide their full names

	Name	Relationship
1		
2		
3		
4		

Please provide the date the tenancy ended or date of sale *(if applicable)* DD / MM / YYYY

Please confirm full names(s) address and contact details of owner(s) of the property if different from those of patient

Postcode Telephone No

If you are acting on behalf of the patient, please state

your full name

Your relationship to the patient

Telephone number

Please advise where correspondence should be sent

Postcode

Do you hold Power of Attorney for the patient *(If yes please provide a copy of this document)* Yes ☐ No ☐

This form should now be given to the hospital, residential or nursing home so that the section overleaf can be filled in.

Part 2 HOSPITAL/RESIDENTIAL/NURSING HOME DETAILS

The person named overleaf has indicated that he/she is currently a patient in your hospital, residential or nursing home.

Could you 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 the hospital / home

Postcode

Date of admission DD / MM / YYYY

Is the patient expected to return home? Yes ☐ No ☐

If yes, expected date of return home DD / MM / YYYY

Is the patient currently awaiting placement in a residential or nursing home? Yes ☐ No ☐

Has the patient been transferred from another hospital, residential or nursing home? Yes ☐ No ☐

Date of transfer DD / MM / YYYY

If yes, please provide the name and address of the hospital, residential or nursing home

Postcode

Please provide the dates the person was a patient at the above

From DD / MM / YYYY To DD / MM / YYYY

Signed Date DD / MM / YYYY

official stamp

Position

Contact Telephone No.

Part 3 DECLARATION BY APPLICANT

I confirm that the information provided by me on this form is both accurate and complete and I undertake to notify the Council immediately of any change in my circumstances which may affect my liability for Council Tax. I understand the Council may make whatever enquiries it considers necessary to verify the information provided by me on this form.

Signature Date DD / MM / YYYY

Print Name Telephone No.

Email Mobile No.

Information provided by you for the purposes of determining Council Tax liability, will be used and stored by Aberdeenshire Council in accordance with the General Data Protection Regulation (GDPR) and the Data Protection Act (DPA) 2018. Please refer to our Council Tax Privacy Notice for more information, which can be found at www.aberdeenshire.gov.uk/online/legal-notices/data-protection/service-specific-privacy-notices/

Please return this form to: Aberdeenshire Council, PO Box 18533, Inverurie, AB51 5WX

If you require help completing this form or further information regarding Council Tax, contact us by:

Telephone
03456 08 12 01

Email
council.tax@aberdeenshire.gov.uk

Visit out Website
www.aberdeeshire.gov.uk/counciltax