Aberdeenshire COUNCIL **Corporate Services**

Council Tax

Property No ....

Name ....
Address ....
....
.... Postcode ....

Reference Number ....
Issue Date ....
Return By Date ....

Hospital/Residential/Nursing Home Enquiry Form

Information

Exemption or Discount may be granted if a person is a patient in a hospital, residential or nursing home. To find out if you qualify for a reduction we need to ask some questions about the patient. Please read the following notes and then fill in the form in BLOCK CAPITALS. (Using black ink)

The patient must meet the following conditions.

- He or she must be resident in the hospital or home continuously, for more than 6 weeks
- The residence must be indefinite or permanent

How to complete this form

If you feel that a person normally resident in your household meets the conditions noted above, we need to find out more about that person.

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 or residential/nursing home**
- Part 3 should be signed by the **liable person** (the person to whom the Council Tax Bill is sent)

Any information given will be treated in the strictest confidence

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 unoccupied? Yes ☐ No ☐

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

Please provide their full names:

1	
2	
3	
4	

Is the property unfurnished? Yes ☐ No ☐ If yes, date property became unfurnished ....

Please provide the date the tenancy ended or date of sale (if applicable)..

This form should now be given to the hospital or residential/nursing home so that Part 2 (overleaf) can be filled in. Please sign the authorisation below:

Signed .... Date ....

Print name ....

If you are not the liable person, please state your relationship and telephone number.

Relationship.. Telephone No ....

Please advise where correspondence should be sent ....

....

Part 2 - Hospital or Residential/Nursing Home details (to be filled in by the hospital or home)

The person named overleaf has indicated that he/she is currently a patient in your hospital/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 ....

....

....

Date of admission .... Is stay long-term? Yes ☐ No ☐

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

Has the patient been transferred from another hospital/home? Yes ☐ No ☐

Date of transfer ....

If yes, please provide the name and address of the hospital/home ....

....

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

Signed ....

Position ....

Date ....

Contact Telephone No ....

If no official stamp, please tick box ☐

OFFICIAL STAMP

Part 3 DECLARATION BY APPLICANT

I declare that the information I have given on this form is correct and complete to the best of my knowledge. I will undertake to inform the Council of any change in my circumstances as soon as the change occurs. I authorise the Council to make any necessary enquiries to verify the information given on this form.

Signature .... Date ....

Print Name .... Telephone No. ....

Email .... Mobile Telephone No. ....

Any information you provide will be used and retained on computer by the Authority and will be shared with other government bodies, including Scottish Water, in accordance with the Data Protection Act 1998.

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

If you wish further information regarding this form or any other Council Tax query, please contact us by:

Telephone: 08456 08 12 01

Email: council.tax@aberdeenshire.gov.uk

Visit our website: www.aberdeenshire.gov.uk/counciltax