COUNCIL TAX

CITY OF YORK COUNCIL

WEST OFFICES, STATION RISE, YORK, YO1 6GA TEL: (01904) 551558

APPLICATION FOR DISCOUNT
CARING FOR DISABLED PERSONS

Date of Issue:_____

Payment Reference: _____
Address of Property: _____
_____
Name of the Taxpayer: _____
Name of Disabled Person
(If different to above): _____

Total number of adults resident in property _____

Is the disabled person entitled to one of the following-

- ☐ **An attendance allowance**
- ☐ **The highest or middle rate of the care component of disability living allowance**
- ☐ **An increase in the rate of their disablement pension or constant attendance allowance**
- ☐ **The standard or enhanced rate of the daily living component of personal independence payment**
- ☐ **An armed forces independence payment**

Please provide proof of entitlement to benefit

Persons to be disregarded – please note you cannot be disregarded if you are the partner of the person being cared for; or if you are the parent of the person being cared for and they are aged under 18.

Full Name	Relationship to disabled person	Average hours per week spent providing care	Date caring commenced

DECLARATION
I declare that the information that is given is, to the best of my knowledge, true and accurate.

Signed Date