Executive Director of Finance
Martin Booth
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Payment Line Number:- 0141-287-0300

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Financial Services
PO Box 36
Glasgow
G1 1JE

COUNCIL TAX EXEMPTION (SUBJECT TO REVIEW) –
LONG TERM HOSPITAL/RESIDENTIAL CARE –UNOCCUPIED PROPERTY

SUBJECT ADDRESS _____

In terms of schedules 2 and 11 of the Local Government Finance Act 1992, and the Council Tax (Exempt Dwellings) Scotland Order 1997 (as amended), a dwelling may be exempt from Council Tax (including the water and sewerage charges) if it falls within the category shown below.

UNOCCUPIED DWELLING:

Which, when last occupied, was occupied by a person who is now receiving hospital care in one of the following establishments in Scotland, England or Wales:

A NHS Hospital, a Residential Care Home, a Military Hospital, a Private Hospital, a Hostel or a Nursing Home.

PROOF REQUIRED (In some instances additional proof may be requested)**:**

- Completion of Section 2 of the attached application form

Please complete the attached form, sign the declaration and return it to

Glasgow City Council
PO Box 36
Glasgow G1 1JE

Supporting evidence from the establishment providing care must also be provided as no Exemption will be granted without supporting evidence.

COUNCIL TAX EXEMPTION (SUBJECT TO REVIEW) –
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NAME OF LIABLE PERSON(S) .....

SUBJECT ADDRESS .....

.....

COUNCIL TAX REFERENCE .....

SECTION 1 - (TO BE COMPLETED BY THE LIABLE PERSON, REPRESENTATIVE OR AGENT)

I, (print name) _____ apply for exemption from Council Tax due on the above property from ____/____/____ until ____/____/____ (inclusive) (leave blank if care is ongoing)

The number of adults (including myself) usually resident in the property is _____

DECLARATION
I confirm that the information on this form is correct and authorise Glasgow City Council to check the details. If the property no longer meets the exemption requirements, I will notify The Council within 21 days. I understand that failure to do so is an offence which may make me liable for a fine of £50 and £200 for each subsequent offence.

Signed _____ Date ____/____/____

Print name here _____

If you are not the liable person please state your relationship _____

Please supply daytime telephone number _____

SECTION 2 - TO BE COMPLETED BY HOSPITAL AUTHORITIES

I confirm that the above patient was admitted to this establishment on ____/____/____

The patient's stay is: permanent ☐ not permanent ☐

The patient's stay became permanent on ____/____/____ (if applicable)

The expected discharge date (if known) is/was ____/____/____ (if applicable)

Please **CIRCLE** the description that best matches your establishment type from the 7 types below -.

N.H.S. HOSPITAL	RESIDENTIAL CARE HOME	HOSTEL
MILITARY HOSPITAL	PRIVATE HOSPITAL	NURSING HOME

If your establishment type is not described above please describe it here: _____

Establishment stamp

Signed: _____

Position: _____

Date: _____/_____/_____

Please supply a daytime telephone number: _____