

This page is about where you live. The answer you give will help us to work out whether you can get help with your rent and/or council tax, or with the service charges that you might have to pay with your rent.

How much is your monthly Council Tax before any benefit? £

What is your Council Tax band?

Do you get a single person discount for living on your own? YES NO

Do you get Council Tax Benefit? YES NO If YES, how much? £

I/we own or pay a mortgage for my/our home. If YES go to question as directed. YES NO

Are you liable to pay rent for your home? YES NO

If YES how much before benefit £

Do you get any Housing Benefit? YES NO If YES, how much? £

If you pay rent, who is your landlord? (eg Council, Housing Association or private landlord)

How many bedrooms does your home have?

Do you pay any Service Charges? YES NO

Do you have a mortgage? YES NO Approximate Balance £

Do you own any property other than the home that you live in? YES NO

What is the approximate value of the property £

PLEASE READ BELOW BEFORE SENDING YOUR QUESTIONNAIRE BACK TO US IN THE PREPAID ENVELOPE.

We may need more information to help us in our assessment. If you prefer to contact someone else (eg. family member or carer) for this information please provide their name and telephone number.

Name Telephone number

Derbyshire County Council's Welfare Rights Service complies with the Data Protection Act 1998. This form only asks for essential information to allow us to comprehensively check your entitlement to benefits. We may store certain information you have provided on computer to allow us to fully support and advise you through the process of making claims for benefits as a result of the answers you have given. With your permission, we will share the information with organisations with whom we work closely and who may be able to provide you with other additional services.

If you do not want us to contact other organisations on your behalf tick this box.

Signature

Date

PLEASE COMPLETE THIS FORM, PAGES 1 – 4, AND PLEASE REMEMBER TO SIGN AT THE BOTTOM OF PAGE 4.

Your title (Mr, Mrs, Ms, Miss) Your first name Other initial/s

Your last name

House number/name Street

Town Postcode

Your telephone number

Your Date of Birth

Your National Insurance Number

Do you have a partner living with you? YES NO

Your partner's first name Other initial/s

Your partner's last name (if different)

Your partner's date of birth

Your partner's National Insurance Number

Do any other people over the age of 18 live in your home? YES NO

What is their relationship to you? (eg. son/carer)

What is their average weekly income? £

Do you have any dependant children living with you? YES NO

If YES, what are their ages? a b c d e

Do you pay for childcare? YES NO What is the charge?

Do you pay this weekly fortnightly monthly

Do you and/or your partner do any paid work? YES NO

If YES, how many hours per week? YOU YOUR PARTNER

Have you had an accident at work, or suffer from any medical condition caused by your work? YES NO



This page is to help us assess whether anyone in your household may qualify for PERSONAL INDEPENDENCE PAYMENT (under 65), ATTENDANCE ALLOWANCE (over 65) or DISABILITY LIVING ALLOWANCE for a child. You do not have to be getting help to receive this benefit. Please tick any boxes that apply.

	YOU	YOUR PARTNER	YOUR CHILD	SOMEONE ELSE
Do you or anyone else have difficulty with: Walking? (eg. get breathless, has a heart condition, can only walk slowly or short distances, or suffer from pain and discomfort when walking)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Being steady on their feet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using stairs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness or falls?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Staying safe when walking outdoors or keeping an eye on?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you or anyone else have difficulty with: Bending, stretching or reaching behind their back?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using their hands? (eg. Doing up buttons or preparing veg)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting into or out of a bath?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shaving or washing their hair?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting out of a chair?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting to, or using the toilet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Remembering things?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communicating? (Even with a hearing aid)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seeing because of visual impairment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you or anyone else need prompting or encouraging or reminding to do daily tasks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Keeping an eye on to ensure that they are safe?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Once in bed for the night do you or anyone else have problems with: Getting up or returning to bed? (eg, to use the toilet, take medication or ease pain)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At night, do you or anyone else need keeping an eye on to ensure that they are safe?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When did these difficulties start?	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

If you have ticked any boxes for your child or someone else, please put their details below:

Their title (Mr, Mrs, Ms, Miss) Their first name Other initial/s

Last name Date of Birth

Their National Insurance Number (If known)

Now please answer questions about your income on Page 3.

Please tell us about any money you have coming in and savings you may have. This helps us to check you are getting the right amount of benefits or whether you are entitled to extra. Please tick all the boxes and fill in the amounts in the spaces below.

Do you have any savings? (Include shares, premium bonds, money in the bank etc.) YES NO

If YES, what is the total of all your personal and joint savings for you and your partner? £

If you work what is your take home pay? YOU £ YOUR PARTNER £

Is this paid: weekly monthly weekly monthly

Does this include Statutory Sick Pay/Statutory Maternity Pay/Statutory Paternity Pay? YES NO

Do you or your partner have any other regular income or Occupational Pension?

Do you or your partner get any of the following Social Security Benefits? Fill in the amounts against each benefit you get.

	YOU	YOUR PARTNER	WEEKLY	4 WEEKLY
Child Benefit	£ <input type="text"/>	£ <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child Tax Credit	£ <input type="text"/>	£ <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
Working Tax Credit	£ <input type="text"/>	£ <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
Jobseeker's Allowance	£ <input type="text"/>	£ <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
Employment and Support Allowance	£ <input type="text"/>	£ <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
Income Support	£ <input type="text"/>	£ <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carer's Allowance	£ <input type="text"/>	£ <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
Personal Independence Payment	£ <input type="text"/>	£ <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disability Living Allowance	£ <input type="text"/>	£ <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
State Retirement Pension	£ <input type="text"/>	£ <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pension Credit/Savings Credit	£ <input type="text"/>	£ <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attendance Allowance	£ <input type="text"/>	£ <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
Industrial Injuries Disablement Benefit	£ <input type="text"/>	£ <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
Universal Credit - Monthly	£ <input type="text"/>	£ <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any other benefit? Weekly/4 Weekly	£ <input type="text"/>	£ <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>

Does anyone get Carer's Allowance for looking after you or your partner? YES NO

Do any children in the household receive Disability Living Allowance? YES NO

Please turn over and fill in the details on Page 4.