

# Blue Badge application / renewal form for an individual

You can also apply on our website  
[www.somerset.gov.uk/bluebadge](http://www.somerset.gov.uk/bluebadge)



Please read the accompanying guidance notes before you start to fill in this form.

If you are renewing your blue badge you must still fill in all relevant sections of this form even though you may have given us this information before.

Use the check list on page 9 of this form before you send it back to us

## Section 1 – Information about the person the Blue Badge is for.

<b>Title (Mr, Mrs, Miss, Ms, other):</b>			
<b>First name(s) (in full):</b>			
<b>Last name:</b>		<b>Last name at birth</b>	
<b>Gender:</b>	Male <input type="checkbox"/> Female <input type="checkbox"/>	<b>Date of birth (DD/MM/YYYY):</b>	
<b>Place of birth:</b>	<b>Town</b>		
	<b>County</b>		
<b>National Insurance number or Child Registration number:</b>			
(see Section 1 of the accompanying guidance notes)			
<b>Current address</b>			
<b>Postcode</b>			
<b>Home phone</b>		<b>Mobile</b>	
<b>Email</b>			
<b>To be more efficient we will send you future Blue Badge correspondence by email. Please tick this box if you do not want us to do this.</b>			<input type="checkbox"/>
<b>Previous address, if you have moved in the last three years:</b>			

<b>Do you currently have a Blue Badge, or have you had a Blue Badge before?</b>		Yes: <input type="checkbox"/> No: <input type="checkbox"/>
If you answered 'Yes'		
What is the serial number on the last badge?		
What is the expiry date of the last badge?		
Which local authority issued the last badge?		

## Section 2 – Questions for 'without further assessment' applicants.

### 2a) People who are severely sight impaired (blind) - see guidance notes

<b>Are you registered as blind (severely sight impaired)?</b>	Yes: <input type="checkbox"/> No : <input type="checkbox"/>
If <b>Yes</b> , please send us a copy of your Certificate of Visual Impairment (CVI) or a BD8 form, signed by a Consultant Ophthalmologist. If you are not able to send this, please tell us (below) which local authority you are registered with so we can check.	

### 2b) People who receive the Higher Rate of the Mobility Component of Disability Living Allowance (this is not attendance allowance)

<b>Do you receive the Higher Rate of the Mobility Component of Disability Living Allowance?</b>	Yes: <input type="checkbox"/> No: <input type="checkbox"/>
If <b>Yes</b> , please send us a copy	

### 2c) People who meet a 'Moving Around' descriptor for the Mobility Component of Personal Independence Payment (PIP)

<b>Have you been awarded a Mobility Component of Personal Independence Payment (PIP)</b>	Yes: <input type="checkbox"/> please complete 2c No : <input type="checkbox"/> Go to section 2d
How many points have you been awarded under the "moving around" activity of the mobility component	
<b>When is your award of this benefit due to end? (DD/MM/YYYY):</b>	
<b>Please send us a copy</b>	

## 2d) People who receive the War Pensioner's Mobility Supplement

Do you receive the War Pensioner's Mobility Supplement?

Yes:  No:

If Yes, have you been awarded this benefit indefinitely?

Yes:  No:

If not when is your award of this benefit due to end? (DD/MM/YYYY):

## 2e) People who receive a benefit under the Armed Forces and Reserve Forces (Compensation) Scheme

Do you receive a benefit under the Armed Forces and Reserve Forces (Compensation) Scheme?

Yes:  No:

## Section 3 – is to be completed if the questions in Section 2 do not apply to you

### Questions for 'subject to further assessment' applicants with walking difficulties.

Please describe in the space below:

- Any medical conditions / disabilities that affect your walking.
- If you know them please state the medical terms for the condition you have been diagnosed with.

How do the conditions / disabilities you described above affect your ability to walk?

Please describe:

- Any surgery or treatment you have undergone, or specialist clinics you have attended in relation to each medical condition / disability you have mentioned.

**Surgeries / courses of treatment / specialist clinics:**

**Dates you received this treatment:**

**What medicines do you take in relation to the conditions / disabilities you described above?**

Medicine	Reason	Dosage	How often

**Please tick whichever statements apply to you and provide further details in the space below. Are you currently:**

Awaiting surgery in relation to the conditions / disabilities described above?	<input type="checkbox"/>
Recuperating from surgery in relation to the conditions / disabilities described above?	<input type="checkbox"/>
Awaiting treatment for any of the conditions / disabilities described above?	<input type="checkbox"/>
Managing your condition / disability because you have been advised it is not expected to improve?	<input type="checkbox"/>

**Please give details of the healthcare professionals or specialists (including your GP) who have been treating you in relation to the conditions / disabilities described above:**

Name	Job title	Hospital / Health Centre	Phone number

**Do you anticipate that your conditions / disabilities will improve in the next three years?**

Yes:  No:

If you ticked 'Yes', please describe how much you expect your conditions / disabilities to improve.

**Please tick as many of the following statements that best describe your general walking ability:**

I am able to walk well, including recreational walks.

I am able to walk around the supermarket on my own to do my own shopping.

I am able to walk and can use public transport for some of my local trips.

I am able to walk, but struggle with longer distances or hills.

I am able to walk, but get breathless if I walk for more than a few minutes.

I am able to walk, but find it too painful to walk for more than a few minutes.

I am able to walk but use a wheelchair for longer trips outside the home.

I am able to walk around my home, but I am unable to climb the stairs.

I am unable to walk at all.

Other (please describe below).

**Are you able to walk outside without the help of another person?**

Yes:  No:  (If **No**, please provide more detail below)

**Where in your local area can you comfortably walk to from your home?** (for example, a shop, street address or park).

**Please tick the box that best describes the way you walk:**

Normal - no specific problems with walking.

Adequate - for example, you walk with a slight limp.

Poor - for example, you walk with a heavy limp, a stiff leg or shuffle, or have problems with balance.

Extremely poor - for example, you drag your leg, stagger, use two crutches or need physical support.

Or if there is not a box that describes the way you walk, please tell us in your own words in the space below.

**Do you use any of the following walking aids?**

(Please tick whichever options apply to you - you can tick more than one box).

1 elbow crutch.

2 elbow crutches.

1 walking stick.

2 walking sticks.

Walking frame (Zimmer frame).

Rollator.

Wheelchair.

Powered wheelchair.

Other (please describe below)

**Were your walking aids.**

Purchased privately

Prescribed by a healthcare professional

Provided by Social Services

Other (please describe below).

<b>How far would you estimate you are able to walk, using any walking aids, before you feel severe discomfort?</b> Please state the distance in metres or yards. (See <b>Section 3</b> of the accompanying guidance notes)			
	metres, or		yards
How much time would you estimate it takes you to walk this distance in minutes?			
Are you able to continue walking after a short rest?			Yes: <input type="checkbox"/> No: <input type="checkbox"/>
If you can continue, roughly how long are you able to walk for in minutes?			
<b>Please answer 'Yes' or 'No' to each of the following questions by ticking the relevant box:</b>			
Do you get short of breath when hurrying on level ground or walking up a slight hill?			Yes: <input type="checkbox"/> No: <input type="checkbox"/>
Do you get short of breath walking with other people of your own age on level ground?			Yes: <input type="checkbox"/> No: <input type="checkbox"/>
Do you have to stop for breath when walking at your own pace on level ground?			Yes: <input type="checkbox"/> No: <input type="checkbox"/>
Do you get too breathless to leave your home, or after dressing?			Yes: <input type="checkbox"/> No: <input type="checkbox"/>
<b>Is there anything else you would like to add in support of your application?</b> Please use addition paper if required			

<b>Section 4 – Questions for 'subject to further assessment' applicants with a disability in both arms.</b>	
Do you drive regularly?	Yes: <input type="checkbox"/> No: <input type="checkbox"/>
Do you have a severe disability in both arms?	Yes: <input type="checkbox"/> No: <input type="checkbox"/>
Please describe below your medical condition / disability:	

<b>Are you unable to operate, or have considerable difficulty operating a parking meter or pay and display machine because of your upper limb disability?</b>	Yes: <input type="checkbox"/> No: <input type="checkbox"/>
If <b>Yes</b> , please describe below the difficulties you have with operating parking meters and pay and display machines:	
<b>Do you drive a specially adapted vehicle?</b>	Yes: <input type="checkbox"/> No: <input type="checkbox"/>
If <b>Yes</b> , please describe how the vehicle has been adapted for you, and enclose a copy of your insurance details verifying this adaptation:	

**Section 5 – Questions for ‘subject to further assessment’ applicants under the age of three.**

<b>Are you applying on behalf of a child under the age of three who has a condition that requires transportation of bulky medical equipment at all times?</b>	Yes: <input type="checkbox"/> No: <input type="checkbox"/> If <b>No</b> , go to section 6 If <b>Yes</b> , please state below what type of equipment it is:
<b>Does the child’s condition mean that they must be kept near a vehicle so that they can, if necessary, be treated or taken quickly to a place where they can be treated?</b>	Yes: <input type="checkbox"/> No: <input type="checkbox"/> If <b>Yes</b> , please describe below the child’s medical condition:
Please enclose a letter from a healthcare professional who has been involved in your child’s treatment (for example your GP or paediatrician) giving details of the child’s medical condition and the type of medical equipment they need. Or you can provide the healthcare professional’s contact details below, so that we can contact them.	

## Section 6 – Declarations and signatures.

- Please read the following declarations thoroughly.
- Please tick all relevant boxes to indicate that you have read and understood each declaration.
- Not ticking one of these declarations may mean we are unable to issue you with a Blue Badge.
- Providing fraudulent information may result in prosecution and a fine.

### Declarations to be completed by all individual applicants

I confirm that the details I have provided are complete and accurate. I realise that you may take action against me if I have knowingly provided false information in this application form.	<input type="checkbox"/>
I understand that I must promptly inform my local authority of any changes that may affect my entitlement to a badge.	<input type="checkbox"/>
I confirm that the photograph I have submitted with my application is a true likeness.	<input type="checkbox"/>
I understand that, if my application is successful, I must not allow any other person to use the badge for their benefit and that I must only use the badge in accordance with the rules of the scheme as set out in the “Blue Badge scheme: rights and responsibilities in England” leaflet which will be sent to me with the badge.	<input type="checkbox"/>
I understand that I must not have more than one valid Blue Badge at any time.	<input type="checkbox"/>
I understand that the local authority may need to contact a healthcare professional for the purpose of obtaining further information in support of my application.	<input type="checkbox"/>
I understand that I may be required to be assessed by a healthcare professional who is independent of my existing care and treatment to determine my eligibility for a Badge.	<input type="checkbox"/>

### Section 6a - Your signature against the declarations in section 6

<b>Your signature:</b>	
<b>Please print your name:</b>	
<b>Date of application:</b> (DD/MM/YYYY)	

## Section 7 - Checklist of documents you need to enclose

### All applicants must enclose the following:

A <b>copy</b> of proof of your identity. (see guidance notes)	<input type="checkbox"/>
One passport-style photograph of yourself with your name on the back.	<input type="checkbox"/>

£10 fee – either cheque or postal order made payable to Somerset County Council	<input type="checkbox"/>
Please make sure you send with your application a <b>copy</b> of the relevant documents for the sections of this application form that you have completed. Here is a checklist to help you.	
<b>Section 2a – People who are severely sight impaired</b>	
A copy of your ophthalmologists report / CVI / BD8 form (if you have not given us consent to check the blind register).	<input type="checkbox"/>
<b>Section 2b – People who received the Higher Rate of the Mobility Component of Disability Living Allowance</b>	
A <b>copy</b> of your letter of entitlement for the Higher Rate of the Mobility Component of Disability Living Allowance issued within the last 12 months or your original annual uprating letter.	<input type="checkbox"/>
<b>Section 2c – People who meet a ‘Moving Around’ descriptor for the Mobility Component of Personal Independence Payment (PIP)</b>	
A <b>copy</b> of your Personal Independence Payment decision letter issued within the last 12 months.	<input type="checkbox"/>
<b>Section 2d – People who receive the War Pensioner’s Mobility Supplement</b>	
A <b>copy</b> of your letter of entitlement for the War Pensioner’s Mobility Supplement.	<input type="checkbox"/>
<b>Section 2e – People who receive an award under the Armed Forces and Reserve Forces (Compensation) Scheme</b>	
A <b>copy</b> of your award letter confirming receipt of tariffs 1-8 under the Armed Forces and Reserve Forces (Compensation) Scheme, which also certifies that you have a permanent and substantial disability which causes inability to walk or very considerable difficulty walking.	<input type="checkbox"/>
<b>Section 4 – Drivers with an disability in both arms</b>	
A <b>copy</b> of your insurance details if you drive a specially adapted vehicle	<input type="checkbox"/>
<b>Section 5 – Children under the age of three</b>	
A letter from a healthcare professional who has been involved in the child’s treatment, giving details of medical condition and type of medical equipment needed.	<input type="checkbox"/>
<b>Returning your application form.</b>	<b>Any questions?</b>
Please send your fully completed application form and supporting documentation (including the correct postage cover) to:  Blue Badge Scheme Bridgwater Social Care Office PO Box 457 Bridgwater House King Square Bridgwater TA6 9GP	If you have any queries, in the first instance please contact us by email at <a href="mailto:BlueBadgeScheme@somerset.gov.uk">BlueBadgeScheme@somerset.gov.uk</a>  If you are unable to email, please phone us on:  01278 447526