

Reimbursement of Non-Domestic Rates

Please read these notes before completing this form.

- Full details of reimbursement are set out in Determination IX of the Statement of Dental Remuneration. Please read the Determination before you fill in this form.
 - Only the **original rate demand**, or a copy certified by the Charging Authority, will be accepted by the Agency, and this should be accompanied by a receipt of payment.
 - All claims should be made **within six months** of date specified by the Department of the Environment - Rating Agency.
 - If you have more than one premises you must make a separate claim for each.
 - The Agency will decide if you are entitled to any reimbursement of your non-domestic rates costs and, if so, make any payment due on your monthly schedule.
 - Only that proportion of the rate which relates to the dental surgery will be reimbursed.
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Part 1 - Personal details

1 Surname _____

2 Forenames _____

3 Dentist Code No.

4 Address of Premises _____

_____ Postcode _____

Telephone Number _____

5 Is there any business, other than dental surgery, carried out on the above premises? Yes No

If "Yes", you will need notification of the proportion of the rate which is for the dental surgery from the Rates Collection Agency. (see Notes)

6 I wish to claim reimbursement for payments made *tick appropriate box*

a By single payment

b By two instalments

c By 10 monthly instalments

7 Please enter the year you are claiming for: _____

Part 2 - Conditions for Claiming

1 Is this your first claim in this financial year? No go to Part 3
Yes please fill in the rest of the form

2 Are you

a Responsible for paying the rates? Yes No
In a partnership which is responsible for paying rates? Yes No
A director of a Limited Company which is responsible for paying rates? Yes No

B On the Dental List? Yes No
An executor of a Dentist whose name remains on the Dental List? Yes No

3 Were the gross earnings from provision of General Dental Services for the premises as a whole for the previous financial year at least £ 23,497.00 (year 2003/2004), £24,178.00(year 2004/2005)and £ 25,000.00 (year 2005/2006). Yes No

4 If you answered "No" to question 3 is there a reason why you think the Agency should waive this requirement? Please explain.

Part 3 - Conditions for Payment

1 You **must** provide:
a The **original** rate demand (or a copy certified by the Rating Agency; and
b A receipt from the Rating Agency for the payment; and
c The proportion of gross income for the premises arising from the provision of general dental services during the last six months of the previous financial year
The proportion was _____ %.

2 The Agency and/or the Area Board must be satisfied that your dental surgery and waiting room accommodation are adequate and furnished with adequate equipment.

Part 4 - Declaration

I declare that:

- Gross earnings from General Dental Services for the premises for the relevant period were at least the figures shown in paragraph 2.(2). C. of Determination IX;
- No other claim has been made by me/any other party/any other executor for the amount now claimed;
- I enclose my demand note and receipt confirming payment of the amount now claimed;
- I shall notify the Agency of any change in circumstances which may effect my entitlement to reimbursement;
- I understand that if the Agency/Area Board considers my premises are inadequate for the provision of General Dental Services they may withhold payment of any reimbursement due until it considers the premises adequate;
- * That the information I have provided on this form is correct and complete and I understand that if it is not action may be taken against me. I understand that the Central Services Agency may request an Accountant's Certificate to confirm the figure provided in respect of any past year gross earnings attributable to work in the General Dental Services and that I must provide it at my own expense within 3 months of the request being made.
- I apply for reimbursement of non-domestic rates in accordance with Determination IX of the Statement of Dental Remuneration.

Signature _____ Date _____

**Now forward this form to GP Payments Office, Central Services Agency
2 Franklin Street, BELFAST BT2 8DQ**

For Agency use only

Date received _____