**Berkshire Healthcare NHS Foundation Trust**

**Funding Application**

Date:

*Please ensure the Patient’s name is represented by their initials only*

|  |  |
| --- | --- |
| **PATIENT INFORMATION** | |
| **Type of request:** | **NEW CONTINUED ADDITIONAL** |
| **Rio Number:** |  |
| **Year of Birth:** |  |
| **Age:** |  |
| **GP Name & Location:** |  |
| Does the person have capacity to make their own decision relating to this service?  If so has written consent been obtained? | YES / NO  YES / NO |
| If not has a formal MCA been recorded and how have you arrived at this decision? (details of best interest decision, role of advocate & IMCA) |  |
| Is the individual subject to S117 aftercare?  If yes, please confirm Section & Date: | YES / NO  Section: Date: / / |
| Mental Health Diagnosis: |  |
| Presenting Physical issues: |  |
| Presenting Mental Health issues: |  |
| **PROPOSER**  *(Please identify the team and details of the staff member submitting this funding application).* | |
| Team: |  |
| Person submitting application: |  |
| Position: |  |
| Date: |  |
| **CURRENT CIRCUMSTANCES**  *(Please explain in full)* | |
| What are the current circumstances of the person? |  |
| Is the individual in receipt of any existing care plan or package of care?  If so, please give details: | YES / NO |
| Have all local options been provided / attempted?  **Please give full details of relevant/recent treatment and interventions provided locally (to date) and their outcomes.** | YES / NO |
| **RISKS** | |
|  | |
| **PROPOSED SUPPORT ARRANGEMENTS** | |
| **SUPPORT** - What is being requested? (details of service/support). |  |
| **PLAN** - Support Plan (day of week - am/pm/ night time etc.) with crisis management (support in place/what will happen if support is not available?) |  |
| **WHY** - Reason for request? |  |
| **OPTIONS** - What other services have been considered? |  |
| **PROVIDERS** - Providers considered, preferred provider, reasons and Care Funding Calculator comparison made | Providers considered:  Preferred provider & why:  Care funding calculator costs: (if appropriate) |
| **INVOLVEMENT** - How has the individual/family been involved in this decision? (include best interest decision making or use of advocate & preferences noted). |  |
| **OUTCOMES** - What outcomes will this service/ support package deliver to the individual? (include over what period of time and the review process) |  |
| **DIVERSITY** - Have the individual’s cultural needs been considered?  If so, how they will be met by proposed intervention/ provider? |  |
| **SAFETY** - CQC report & safeguarding checks completed? |  |
| **FINANCIAL INFORMATION** | |
| Cost details:  Current and/or proposed (per week) | £ |
| Is this a Joint or Sole application to Health? If Joint please confirm **%** split proposed:  Has LA funding application been submitted / approved? | %  YES / NO |
| **Clinical Information** | |
| Is this application supported by the Clinical team involved in the patients care? Care Co-ordinator/Clinical Lead, Consultant Psychiatrist | YES / NO |

Signed: Date:

Care Co-ordinator /

Person completing form:

Consultant Psychiatrist: Date:

Locality Manager: Date:

East Panel

Representative: Date: