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| **Children’s Individual Funding (CIF) Request** |
| **ESSENTIAL INFORMATION-PLEASE READ:** |
| **This form is to be completed when requesting additional NHS services or funding for children and young people with complex health needs. When completing this form you must confirm that:*** **This child’s clinical needs are not or cannot be met by any locally commissioned services**
* **The child’s clinical needs have been identified and assessed by a Health Professional**
* **The Referrer regularly review the package (therapy or mentoring is usually commissioned in blocks of 12 sessions, there is an expectation we receive a report from the therapist before further blocks are commissioned)**
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| **PART ONE: TO BE COMPLETED BY REFERRER****Child or Young Person’s Details**  |
| Name: |  |
| Date of birth:  |  | NHS Number: |  |
| Address:  |  |
| Gender (delete as appropriate): | Male Female  | Preferred pronoun: |  |
| First language: (if not English)  |  | Translator needed: |
| Other communication support needed: |
| Mother’s name:  |  | Father’s name:  |  |
| Contact no.  |  | Contact no.  |  |
| NB. Details of one parent only are acceptable, but it must be the parent with responsibility.  |
| If Parental Responsibility Is Not Held by Parents:  |
| Parental responsibility held by: |  | Contact no.  |  |
| E-mail: |  |
| **Professionals involved:**  |
| Name and address of GP: |  |
| Consultant name and contact details: | Eg Paediatrician, CAMHS Psychiatrist, Specialist Consultant |
| Other professionals: |  |
| Local Authority:  |  |
| **History** |
| Please provide a pen picture of the young person. |  |
| Please provide details of health need e.g. diagnosis, history, formulation  |  |
| Which local health services has the child or young person already accessed? If none, have referrals been made to local services before making this request? |  |
| How successful was this intervention? |  |
| **Details of the request**  |
| What are you requesting for the child/young person? e.g. Individual therapy, mentoring |  |
| How will this meet their needs? |  |
| Who is making the clinical recommendation and why?  |  |
| **Costing/Evidence/Outcomes** |
| Please provide a breakdown of the cost. This should be obtained from the provider. Give a detailed breakdown of individual health specific intervention/s, including number of sessions/cost per session |  |
| Please provide evidence to support this referral. e.g. assessments, clinic letters, reviews. Please list and attach. |  |
| How will the outcomes be monitored? i.e. CIN review, CPA, therapist report |  |
| **PLEASE TICK THE BOXES BELOW****THIS FORM WILL NOT BE ACCEPTED IF ALL THREE DO NOT APPLY** |

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| **Consent** ✓ as appropriate |  | **Yes** | **No** |
| I have consent to share information about the child or young person and to make this request. |  |  |  |
| **Supporting evidence** ✓ as appropriate |  | **Yes** | **No** |
| I have provided supporting evidence which is up to date and relevant to the best of my knowledge. |  |  |  |
| **Costing** ✓ as appropriate |  | **Yes** | **No** |
| I have attached the breakdown of costs from the provider. |  |  |  |

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| **Referrer Details** |
| Date of Referral Completed: |  |
| Name of Referrer |  |
| Job Title and Organisation: |  |
| Contact no. |  |
| E-Mail: |  |
| The referral form must be forwarded to the Children’s Complex Care Team at:BNSSG CCG

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| **E-Mail**: bnssg.cc.childrens@nhs.net **Tel**: 0117 984 1656 |

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| **PART TWO: TO BE COMPLETED BY CCG AFTER PANEL/CASE MANAGEMENT MEETING AND RETURNED TO REFERRER AS AN AGREEMENT TO FUND** |
| **Panel Decision**  |
| CCC Panel Date: |  | Funds Agreed: | £ per week/month/year (delete as appropriate) |
| Start Date: |  | Review Date: |  |
| End Date/Duration |  | QA no (for invoicing): |  |
| Comments/Rationale for Decision: |
| CCG Invoicing Details: |
| Please send invoices to:XXFCOOMBENHS BRISTOL NORTH SOMERSET AND SOUTH GLOUCESTERSHIRE CCG 15C PAYABLES M485 PHOENIX HOUSE TOPCLIFFE LANE WAKEFIELD WF3 1WE |
| Name: |  | Position: |  |
| Signature: |  | Date: |  |

For CCG use:

[S:\(BNSSG Area)\Children & Young People's Complex Care\Documents\Funding Auth Form\Funding Auth V1.xlsx](file:///S%3A%5C%28BNSSG%20Area%29%5CChildren%20%26%20Young%20People%27s%20Complex%20Care%5CDocuments%5CFunding%20Auth%20Form%5CFunding%20Auth%20V1.xlsx)