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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)** | | | | | |
| **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   |  | | --- | | **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:  XXFCOOMBE  NHS 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:\(BNSSG%20Area)\Children%20&%20Young%20People's%20Complex%20Care\Documents\Funding%20Auth%20Form\Funding%20Auth%20V1.xlsx)