STRICTLY CONFIDENTIAL

On behalf of
Hambleton, Richmondshire and Whitby CCG
Harrogate and Rural District CCG
Scarborough and Ryedale CCG

APPLICATION FORM FOR NHS FUNDED CARE

Please return the completed application form to: **SCRCCG.chcdocuments@nhs.net**

Continuing Healthcare Team
Kingswood House
2nd Floor
14 Wetherby Road
Harrogate
HG2 7SA

Tel 0300 303 8674

Date received (for NHS Continuing Care Admin only): ……

Request for:	Funded Nursing Care Assessment		Respite	
	Full/Joint Health Funding		New referral	
	Fast Track		Change in condition	

PERSONAL DETAILS

Surname: ……

First Name: ……

Title: ……

DoB:: ……..

NHS Number: ……

LLA: ……..

Gender: ……

	Discharge address (If different from home)
Address: ……	……..
……	……
……	
Postcode: ……	Postcode: …….
Tel: ……..	Tel: ……

General Practitioner:	**Next of Kin/Carer details:**
Name: ……..	Name: ……
Address: ……	Relationship: ……..
……	Address: ……...
Postcode: ……...	……..……Postcode: …….
Tel: ……..	Tel: …….

Discharge Date (if known)	**FNC Respite Dates (if known)**
……	……

CLIENT'S NAME: …… DoB: ……

Patient' Current Location:	
Home address (please tick box):	Hospital: ……
Ward: ……..	Tel: ……
Details of other professionals involved: …… Tel: …… …….. Tel: …… …… Tel: …… …… Tel: ……	

Social Care Assessor:	Tel:
Office base	
Responsible Local Authority: North Yorkshire/ City of York/ Other (Please delete as applicable)	

Funding Source – FNC only (Please tick box):			
Health & Adult Social Services	□	Self Funding:	□

Diagnosis and Case Summary (Please attach additional sheet if required):

Current Care Arrangements:	**Current Funding Arrangements**	
	Health and Adult Services	
	Cont Health Care	
	Education/LSC	
	Client Contribution	
	Other	
	TOTAL	

CLIENT'S NAME: …… DoB: ……

Proposed Care Arrangements:

Care Provider and Address: ……..

……....

……

Tel: ……...

Contact details of any representatives that need to be involved:

Contact name: ……..…….

Relationship: ……

Contact address: ……..……..

……

……

Tel: ……...

Is there any known reason why the CHC Nurse Assessor may need a chaperone when visiting e.g. Safety issues?

CLIENT'S NAME: …… DoB: ……

To process this application the following documents, signed and dated must accompany this form:	
CHC Checklist	
Nursing assessment	
Consent **	
Details of other health care professionals involved	

** **PLEASE OBTAIN CONSENT FROM CLIENT BEFORE RETURNING THIS FORM. FAILURE TO DO SO WILL DELAY THE PROCESS**

Preferred Language/Ethnicity: ……..

Referred by:	
Please print name:	
Location:	
Tel:	
Date:	