

**Application Form for Temporary One to One Support for a Care Home Resident**

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| **Service User/**  **Patient Name:** |  | | | | |
| **Date of Birth:** |  | | **Date of Admission:** |  | |
| **NHS Number:** |  | | **Liquid Logic or Broad Care Number:** |  | |
| **Home Address:**  **Telephone Number:** | **Or** | | | | |
| **Current GP:**  **Practice Address:**  **Telephone Number:** |  | | | | |
| **Currently Funded by:** | **Continuing Healthcare/**  **Funded Nursing Care** | **Local Authority** | | | **Self-Funder** |
| **Name of CCG funding the patient:** | | | | |
| **Request Completed By:**  **(Name and Role)** |  | | | | |
| **Other Professionals Involved** | **Name** | | **Contact Number & Email** | | |
| **Social Worker** |  | |  | | |
| **Community Mental Health Worker** |  | |  | | |
|  |  | |  | | |
| **Medical History (include diagnosis dates if known)** | | | | | |
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| **Summary of Current Health Needs** | | | | | |
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| **Request for Extra Funding (include the number of hours required daily and anticipated length of time required)** | | | | | |
|  | | | | | |
| **Reason Extra Funding Requested (include details of expected outcome)** | | | | | |
|  | | | | | |
| **Signed:** | | | **Dated:** | | |