

Post original to Shaw Trust Direct Payments Support Service BANES, PO Box 1890, Bristol, BS37 4WW

Please Note: Incomplete forms cannot be processed and will be returned.

Please call 01454 32 60 70 if you need assistance.

Section A: User Details:		Potential User <input type="checkbox"/>	User <input type="checkbox"/>
Title:	<input style="width: 100%;" type="text"/>	First Name:	<input style="width: 100%;" type="text"/>
Family Name:	<input style="width: 100%;" type="text"/>		
Client ID:	<input style="width: 100%;" type="text"/>	Nat Ins No:	<input style="width: 100%;" type="text"/>
Tel No:	<input style="width: 100%;" type="text"/>	Mobile No:	<input style="width: 100%;" type="text"/>
Address:	<input style="width: 100%;" type="text"/>		
Postcode:	<input style="width: 100%;" type="text"/>	Date of Birth:	<input style="width: 100%;" type="text"/>
E-mail Address:	<input style="width: 100%;" type="text"/>		
<hr/>			
Person Managing DP on behalf the Service User:	<input style="width: 100%;" type="text"/>		
Relationship:	<input style="width: 100%;" type="text"/>		
Tel No:	<input style="width: 100%;" type="text"/>	<i>If managing DP yourself please answer N/A</i>	
<hr/>			
Care Manager/Support Planner:	<input style="width: 100%;" type="text"/>		
Team:	<input style="width: 100%;" type="text"/>		
Location:	<input style="width: 100%;" type="text"/>		
Tel No:	<input style="width: 100%;" type="text"/>		
E-mail Address:	<input style="width: 100%;" type="text"/>		

Section B: Direct Payment User Group: (Please ✓ those which apply)			
Learning Disability/Difficulty:	<input type="checkbox"/>	Mental Health Issue:	<input type="checkbox"/>
Physical Disability:	<input type="checkbox"/>	Sensory Impairment:	<input type="checkbox"/>
Other/Not Specified:	<input type="checkbox"/>	Children's Services:	<input type="checkbox"/>
<hr/>			
16 - 17 years old:	<input type="checkbox"/>	18 - 64 years old:	<input type="checkbox"/>
Over 65 years old:	<input type="checkbox"/>	Carer:	<input type="checkbox"/>

Section C: Potential Direct Payment Details:

Is this a new package?

'P' Number:

Is this a Direct Payment?

Is this an Individual Budget?

Is the ILF involved?

Care/Support Plan attached?

Section D: Funding:

Has Funding been agreed?

If 'Yes' please provide details below:

	No. Hrs/Days	Rate	TOTAL
Personal Assistant Rate	hrs	@ £ per hr	£
Agency Rate	hrs	@ £ per hr	£
Day Rate	days	@ £ per day	£
Meals Service	days	@ £ per day	£
Sleep In/Waking Night		@ £	£
Sleep In/Waking + 24hrs		@ £	£
Short Term Break rate	days	@ £ per day	£
One-Off Payment for:			£

Total Gross Payment per week:

Less Financial Contribution per week:

Total Amount of Direct Payment per week (i.e. Net Payment):

Other agreed expenses (e.g. set up costs):

Or One-Off Payment of:

What type of support is required?

Personal Care

Social Activities

Section E: Accessibility:

Will meetings require an interpreter?

If yes, what language?

What alternative formats will be needed?

Is a Risk Assessment attached?

Is a joint visit required?

Is the DP User's home accessible to wheelchair users/people with mobility issues?

Provide details of physical access to the user's premises:

(Please consider potential access issues such as stairways, lifts, gravel pathways etc. and personal safety issues such as lighting, isolation etc.)

THIS FORM IS 5 PAGES TOTAL, PLEASE ENSURE THE APPROPRIATE SECTIONS ARE COMPLETED.

Shaw Trust Direct Payments Support Service BANES Tel/Fax: 01454 32 60 70 E-mail: clare.gray@shaw-trust.org.uk

Section F: Any Other Comments/Notes:

Indication of Support Option:

Section G: Consent to Disclose:

I confirm that the information contained in this form is true to the best of my knowledge and I have obtained verbal consent from the potential DP user to agree to Shaw Trust obtaining and processing all information provided on this form.

Please tick

Date:

Care Manager/Support Planner Name:

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Section H: Data Protection: To be Completed with the Shaw Trust Officer

The information contained in this form is true to the best of my knowledge and I agree to Shaw Trust obtaining and processing all confidential information provided by me and agree for it to be disclosed for the purposes of carrying out the service:

Potential DP User Signature:

Officer Name:

Date:

Section I: Health & Safety: To be Completed with the Shaw Trust Officer

HEALTH AND SAFETY DECLARATION - The Health and Safety at Work Act is a Government Act designed to ensure that everyone stays safe and healthy and is protected when at work. If successful in securing employment either independently or through the Shaw Trust I acknowledge that I am responsible for requesting training and / or advice on health and safety from my employer.

Potential DP User Signature:

Section J: Referral Outcome: To be Completed by the Shaw Trust Officer

Date Referral Received:

Date of Call Back:

Outcome:

1st Meeting Date:

2nd Meeting Date (if applicable):

Referral Closed: (Tick)

Next Steps Agreed: (Tick)

Reason for Closure: (Tick)

Referral to Social Services

User Change of Circumstances

Date

User Ineligible

Action Planning

User No Further Interest

Follow Up Call in weeks

User Unwell

Regarding

Inappropriate Referral

Other (describe)

Other (describe)

Section K: Notes: To be Completed by the Shaw Trust Officer

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Section L: Equal Opportunities: To be Completed with the Shaw Trust Officer

Shaw Trust is committed to Equal Opportunities. To enable us to monitor the effectiveness of our Equal Opportunities Policy, we need to collect the following information. The information will be used for statistical monitoring only, is confidential and this section of the form will be detached and stored separately from your personal details.

Project Code: 4205 M4500

Please tick the appropriate boxes:

Gender

Male

Female

How would you describe your ethnic origin or racial group?

Black – African

Black – Caribbean

Black – Other

Bangladeshi

Chinese

Indian

Irish

Pakistani

White

Other

Please describe:

Prefer not to say