NHS
Dorset
Clinical Commissioning Group

NHS CONTINUING HEALTHCARE FUNDING
APPLICATION FORM

FULL NAME **(person who funding is for)**	
NHS NUMBER	
ADDRESS	
DATE OF BIRTH	
DATE OF DEATH (if applicable)	
NAME OF CURRENT/LAST GP	
ADDRESS	
GP TELEPHONE NUMBER	

FULL NAME OF APPLICANT **(if different from above)**	
ADDRESS	
TELEPHONE NUMBER	
MOBILE TELEPHONE NUMBER	
RELATIONSHIP TO PATIENT	
ARE YOU THE INDIVIDUAL'S LEGAL REPRESENTATIVE?	*tick box ☐ *Yes ☐ *No

FULL DETAILS OF CURRENT CARE PROVIDER		
PROVIDER NAME AND ADDRESS	**FROM**	**TO**

DETAILS OF ANY RECENT HOSPITAL ADMISSIONS		
NAME OF HOSPITAL	**FROM**	**TO**

NAME OF SOCIAL WORKER/CARE MANAGER	
LOCAL AUTHORITY	
ADDRESS	
TELEPHONE NUMBER	

DETAILS OF SPECIALIST SERVICES INVOLVED IN PATIENT'S CARE (e.g. Community Mental Health Team, Speech and Language Therapy Service, Tissue Viability Nurse)		
NAME OF SPECIALIST SERVICE	**FROM**	**TO**

PLEASE PROVIDE A BRIEF SUMMARY OF THE PATIENT'S CARE NEEDS (e.g. mobile with Zimmer, hoisted, needs feeding, incontinent etc.)

PLEASE USE THIS SPACE TO PROVIDE US WITH ANY FURTHER RELEVANT INFORMATION TO SUPPORT YOUR APPLICATION

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APPLICATION FOR CONSIDERATION OF ELIGIBILITY
FOR NHS CONTINUING HEALTHCARE FUNDING AND NHS-FUNDED NURSING CARE

CONSENT FORM

FULL NAME(person who funding is for)	
NHS NUMBER	
DATE OF BIRTH	
HOME ADDRESS	
CURRENT ADDRESS (if different from above)	
DATE OF APPLICATION	
NAME OF GP	
GP ADDRESS	
GP TELEPHONE NUMBER	

I/My representative have had an explanation regarding this application and process for NHS Continuing Healthcare funding and NHS-funded Nursing Care. I also understand that this may affect any benefits and/or allowances that I am currently entitled to claim. I understand that any decision to award NHS funding will be subject to continuous review.

*please tick box***Yes** ***No** ☐ ☐

This consent form must be completed by either the individual to whom the application relates to, or their legal representative.
I *Do/Do Not wish to have my representative/advocate identified below present at my assessment/review (*please delete)

REPRESENTATIVE'S NAME	
RELATIONSHIP TO INDIVIDUAL	
ADDRESS	
TELEPHONE NUMBER	

I agree that confidential information relating to the individual who the funding is applied for may be disclosed to the Clinical Commissioning Group reviewing the case, only in so far as is necessary for a decision to be made about this application and the arrangement of care. This information may not be used in relation to any other case or in relation to any other matter I may wish to raise with the Clinical Commissioning Group concerned.

*please tick box ***Yes** ***No** ☐ ☐

Consent To The Assessment Process & Information Sharing

The Mental Capacity Act set out the definition of a person who lacks capacity. These sections of the Act say that a person lacks capacity if he, or she, has a temporary or permanent impairment of/or a disturbance in the functioning of the mind or brain when the decision needs to be made, and as a result is unable to:

- Understand the information relevant to that decision
- Retain that information
- Weigh up information as part of the process of making the decision or
- Communicate his/her decision (whether by talking, using sign language or any other means)

Where the person is incapacitated and unable to consent, information should only be disclosed in their best interests and then only as much information as is needed to support their care. For further guidance, see the Mental Capacity Act 2005 Code of Practice on www.dca.gov.uk/menincap/legis.htm and the guidance booklet "Making Decisions: a guide for people who work in health and social care" on www.dca.gov.uk/legal-policy/mental-capacity/mibooklets/booklet03.pdf

WHO HOLDS FORMAL DECISION MAKING RESPONSIBILITY FOR BELOW?(*please tick appropriate box)			*Self or *Other (*delete as appropriate)
LASTING POWER OF ATTORNEY	LEVEL OF POWER	☐ *Health/Welfare	☐ *Financial
DEPUTY	LEVEL OF POWER	☐ *Health/Welfare	☐ *Financial
ENDURING POWER OF ATTORNEY	LEVEL OF POWER	☐ *Health/Welfare	☐ *Financial
DATE DECISION MADE:			

PLEASE ENCLOSE A COPY OF YOUR SUPPORTING LEGAL EVIDENCE

IF THE PERSON IS DEEMED TO HAVE CAPACITY:-*tick box as appropriate

HAS THEIR CONSENT BEEN OBTAINED FOR THIS ASSESSMENT?	☐ *Yes ☐ *No
HAVE THEY GIVEN CONSENT TO HAVE INFORMATION SHARED WITH THEIR NOK, MAIN CARER OR ADVOCATE?	☐ *Yes ☐ *No
HAS THEIR CONSENT BEEN OBTAINED FOR SHARING INFORMATION CONTAINED WITHIN THIS ASSESSMENT WITH POTENTIAL CARE PROVIDERS?	☐ *Yes ☐ *No
IF THE INDIVIDUAL IS DEEMED TO NOT HAVE CAPACITY TO CONSENT HOW WAS THIS DETERMINED?	
HOW HAS IT BEEN DECIDED AND BY WHOM, THAT IT IS IN THE PERSON'S BEST INTERESTS TO COMPLETE THIS ASSESSMENT?	
Assessor Print Name:	**Designation:**
Signature:	**Date:**
Signature of Assessed Person:	
Signature of Assessed Person's Representative:	

Dorchester Based Continuing Healthcare Team **Third Floor East** **Vespasian House** **Barrack Road** **Dorchester, DT1 1TG** **Tel: 01305 361123**	**Poole Based Continuing Healthcare Team** **Canford House** **Discovery Court Business Centre** **551-553 Wallisdown Road** **Poole BH12 5AG** **Tel: 01202 541581**