

**CONSENT TO ACCOMPANY APPLICATION FOR CONSIDERATION OF ELIGIBILITY  
FOR NHS CONTINUING HEALTHCARE FUNDING AND NHS-FUNDED NURSING CARE**

**CONSENT FORM**

<b>FULL NAME(person who funding is for)</b>	
<b>NHS NUMBER</b>	
<b>DATE OF BIRTH</b>	
<b>HOME ADDRESS</b>	
<b>CURRENT ADDRESS (if different from above)</b>	
<b>DATE OF APPLICATION</b>	
<b>NAME OF GP</b>	
<b>GP ADDRESS</b>	
<b>GP TELEPHONE NUMBER</b>	
<p><b>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.</b></p> <p>*please tick box*<b>Yes</b> <input type="checkbox"/> <b>*No</b> <input type="checkbox"/></p>	
<p>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)</p>	
<b>REPRESENTATIVE'S NAME</b>	
<b>RELATIONSHIP TO INDIVIDUAL</b>	
<b>ADDRESS</b>	
<b>TELEPHONE NUMBER</b>	

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](http://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](http://www.dca.gov.uk/legal-policy/mental-capacity/mibooklets/booklet03.pdf)

<b>WHO HOLDS FORMAL DECISION MAKING RESPONSIBILITY FOR BELOW?(*please tick appropriate box)</b>		<b>*Self or *Other (*delete as appropriate)</b>	
<b>LASTING POWER OF ATTORNEY</b>	LEVEL OF POWER	<input type="checkbox"/> *Health/Welfare	<input type="checkbox"/> *Financial
<b>DEPUTY</b>	LEVEL OF POWER	<input type="checkbox"/> *Health/Welfare	<input type="checkbox"/> *Financial
<b>ENDURING POWER OF ATTORNEY</b>	LEVEL OF POWER	<input type="checkbox"/> *Health/Welfare	<input type="checkbox"/> *Financial
<b>DATE DECISION MADE:</b>			

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?	<input type="checkbox"/> *Yes	<input type="checkbox"/> *No
HAVE THEY GIVEN CONSENT TO HAVE INFORMATION SHARED WITH THEIR NOK, MAIN CARER OR ADVOCATE?	<input type="checkbox"/> *Yes	<input type="checkbox"/> *No
HAS THEIR CONSENT BEEN OBTAINED FOR SHARING INFORMATION CONTAINED WITHIN THIS ASSESSMENT WITH POTENTIAL CARE PROVIDERS?	<input type="checkbox"/> *Yes	<input type="checkbox"/> *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?		
<b>Assessor Print Name:</b>	<b>Designation:</b>	
<b>Signature:</b>	<b>Date:</b>	
<b>Signature of Assessed Person:</b>		
<b>Signature of Assessed Person's Representative:</b>		
<p style="text-align: center;"><b>Dorchester Based Continuing Healthcare Team</b>  <b>Vespasian House</b>  <b>Barrack Road</b>  <b>Dorchester</b>  <b>Dorset DT1 3QY</b>  <b>Tel: 01305 361123</b></p>		