

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

|  |  |
| --- | --- |
| **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)** |
|  |
| **Summary of Current Health Needs** |
|  |
| **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:** |