|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **REQUEST TO AMEND A PERSONAL BUDGET - non RESIDENTIAL**  The Personal Budget must be sufficient to meet the persons assessed care and support needs and reflect market conditions*.*  *(The Care Act 2014. S26 Personal Budgets)* | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| **Persons Details** | | | | | | | | | | | | | |
| Name: | *Person Name* | | | | | | | Mosaic ID: | | | *Person ID* | | |
| Home Address: | | *Person Address* | | | | | | | | | | | |
| **Personal Weekly Budget** | | | | | | | | | | | | | |
| Support hours required to meet Outcomes: | | | | | | **RATE** | **HRS** |  | **COST** *(per Hr)* | | | **TOTAL** |  |
| *Enter number of hrs required in multiples of 0.5 for the applicable Rate* | | | | | | **Standard** | **0.0** | @ | **£19.00** | | | **£0.00** |  |
|  | | | | | | **Urban** | **0.0** | @ | **£21.85** | | | **£0.00** |  |
|  | | | | | | **Rural** | **0.0** | @ | **£22.40** | | | **£0.00** |  |
|  | | | | | | **Isolated** | **0.0** | @ | **£25.65** | | | **£0.00** |  |
| **Personal Weekly Budget:** | | | | | | | | | | | | **£0.00** |  |
| **Available Support within *(or close to)* the Personal Budget explored** | | | | | | | | | | | | | |
| *Prime Provider* | | | *Describe the outcomes this provider would be* ***unable*** *to meet and explain why* | | | | | | | | | | |
| *Alternative Provider* | | | *Describe the outcomes this provider would be* ***unable*** *to meet and explain why* | | | | | | | | | | |
| *Alternative Provider* | | | *Describe the outcomes this provider would be* ***unable*** *to meet and explain why* | | | | | | | | | | |
| **Support Requested** | | | | | | | | | | | | | |
| *Provider Name* | | | | | | |  | | | | | | |
| Provider Care Rate: | | | | | | | **HRS** |  | **COST** *(per Hr)* | | | **TOTAL** |  |
|  | | | | | | | **0.0** | @ | **£0.00** | | | **£0.00** |  |
| Please explain why the proposed provision is the **ONLY** provision that can meet the Support Outcome | | | | | | | | | | | | | |
| *Type your text here* | | | | | | | | | | | | | |
| **Request Details** | | | | | | | | | | | | | |
| Date for increased budget requested from: | | | | *Select Start Date* | | | | | | | | | |
| *Practioner’s Name* | | | | |  | | | | | *Select Current Date* | | | |
|  | | | | | *Signature* | | | | |  | | | |
| *Lead Practioner’s Name* | | | | |  | | | | | *Select Current Date* | | | |
|  | | | | | *Signature* | | | | |  | | | |
| **Request Outcome** | | | | | | | | | | | | | |
| *Choose an Outcome* | | | | | | | | | | | | | |
| *Service Head’s Name* | | | | |  | | | | | *Select Current Date* | | | |
|  | | | | | *Signature* | | | | |  | | | |
| **Further Action Required** | | | | | | | | | | | | | |
| *Type text here* | | | | | | | | | | | | | |

|  |  |
| --- | --- |
| **Review Date:** | *Select Review Date* |