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| **REQUEST TO AMEND A PERSONAL BUDGET FOR A RESIDENTIAL OR NURSING PLACEMENT**  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: | *Enter Person Name here* | | | | | | | | | | Mosaic ID: | | | | *Enter* *Person ID here* | | |
| Home Address: | | | *Enter Person Address here* | | | | | | | | | | | | | | |
| Assessed Care Level Personal Budget: | | | | | | | *Select from available Care Levels* | | | | | | | | | | |
| **Proposed Placement Details** | | | | | | | | | | | | | | | | | |
| Placement Name: | | | | *Enter* *Provider Name here* | | | | | | | | | | | | | |
| Placement Address: | | | | *Enter* *Provider’s Address here* | | | | | | | | | | | | | |
| Room No: | | *Enter* *Room No.* | | | | Additional Room Cost: | | | **£** *Amount***.00** | | | Within Contract Schedule? | | | | | *Select Yes or No* |
| **Placement Type** *(If Short Term Placement, enter the* ***Planned End*** *Date)* | | | | | | | | | | | | | | | | | |
| *Select from available Placement Types* | | | | | | | Date To: | | | | | | *Enter Planned End Date* | | | | |
| **Alternative Placements Explored** | | | | | | | | | | **NOTE** | | | | | | | |
| *1 Enter Provider Name here* | | | | | *Describe the outcomes that this placement would be unable to meet and explain why here* | | | | | | | | | | | | |
| *2 Enter Provider Name here* | | | | | *Describe the outcomes that this placement would be unable to meet and explain why here* | | | | | | | | | | | | |
| *3 Enter Provider Name here* | | | | | *Describe the outcomes that this placement would be unable to meet and explain why here* | | | | | | | | | | | | |
| Please explain why the proposed placement is the **ONLY** suitable accommodation to justify the increased PB | | | | | | | | | | | | | | | | | |
| *Type your explanation here* | | | | | | | | | | | | | | | | | |
| **Request Details** | | | | | | | | | | | | | | | | | |
| Date for increased budget requested from: | | | | | | | *Select Start Date* | | | | | | | | | | |
| *Enter Practioner’s Name here* | | | | | | *Select Current Date* | | | | *Enter LP’s Name here* | | | | | | *Select Current Date* | |
| **PRACTIONER** | | | | | |  | | | | **LEAD PRACTIONER** | | | | | |  | |
| **Request Outcome** | | | | | | | | | | | | | | | | | |
| *Select available Outcome* | | | | | | | | | | | | | | | | | |
| *Enter Head of Service Name here* | | | | | | | | *Paste Signature here* | | | | | | *Select Current Date* | | | |
|  | | | | | | | | **HEAD OF SERVICE** | | | | | |  | | | |
| **Further Action Required** | | | | | | | | | | | | | | | | | |
| *Enter any further actions required here* | | | | | | | | | | | | | | | | | |

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