**Personal Health Grants (Single Payment Discharge Grant) Referral Form**

**Patient Details:**

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | NHS Number: |  |
| Address: |  | Tel Number: |  |
| Post Code: |  |  |  |
| Individuals’ current location: *(Hospital & Ward, Care Setting or Home Address):* | |  | |
| Preferred contact / Representative: |  | Tel Number: |  |

**Referrers Details:**

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | Role: |  |
| Contact number: |  | Email address: |  |

**Consent for Referral:**

|  |  |  |  |
| --- | --- | --- | --- |
| Has this referral for a Personal Health Grant (Single Payment Discharge Grant) been discussed and agreed with the patient and/or their representative? | | | |
| Yes/No |  | Discussion held with: |  |
| Has the patient, or their representative, been informed that by agreeing to the referral for a Personal Health Grant (Single Payment Discharge Grant) to be made, their personal data will be shared with the ICB and their providers as appropriate? | | | |
| Yes / No |  | Additional information/comments |  |

**Request for Grant:**

|  |  |
| --- | --- |
| Estimated Discharge Date | Date: |
| Confirmed Discharge Date *(Where available)* | Date: |
| Please indicate predicted impact of receiving a grant (number of days discharge brought forward etc.) *This must reduce length of stay by a minimum of 2 days* | Days: |
| Please detail how the grant will support discharge including how it will be used  *PHBs are not intended to fund direct care but can provide funding for associated tasks with an aim to reduce demand on formal support without duplicating existing support, services or funding* | |
| **Name:** | |
| **Signature:** | |

**ALL REFERRALS TO BE SENT TO:** [sxicb.ccgphg@nhs.net](mailto:sxicb.ccgphg@nhs.net)

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**ICB Office use only:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Referral NHS number |  | | | |
| Referral received | Date and Time: | | | |
| Referral sent for approval | Date and Time: | | | |
| More information requested *(Detail request in email)* | Date and Time: | | | |
| Maximum sum approved (delete as appropriate) | **£1,000** | YES / NO | **Over £1,000** | YES / NO |
| Approvers Name (Print) |  | | | |
| Approvers Signature |  | | | |
| Date and Time Approved: |  | | | |
| Referral declined and reason |  | | | |