Berkshire Healthcare
NHS Foundation Trust

Funding application for out of area placement (OAP)

Please ensure the patient's name is represented by their initials only.

Date:		
PATIENT INFORMATION		
Type of request: ☐ New ☐ Continued ☐ Additional		
Rio Number:		GP Name and Location:
Year of Birth:	Age:	
Does the person have capacity to make their own decision relating to this service?		☐ Yes ☐ No
If so, has written consent been obtained?		☐ Yes ☐ No
If not has a formal MCA been recorded and how have you arrived at this decision? (details of best interest decision, role of advocate & IMCA)		
Is the individual subject to S117 aftercare?		☐ Yes ☐ No
If yes, please confirm Section & Date:		Section: Date:
Mental health diagnosis:		
Presenting physical issues:		
Presenting mental health issues:		

PROPOSER *(Please identify the team and details of the staff member submitting this funding application).*	
Person submitting application:	
Position:	Team:
Date:	
CURRENT CIRCUMSTANCES *(Please explain in full)*	
What are the current circumstances of the person?	
Is the individual in receipt of any existing care plan or package of care? ☐ Yes ☐ No	
If so, please give details:	
Have all local options been provided/ attempted? ☐ Yes ☐ No	
Please give full details of relevant/recent treatment and interventions provided locally (to date) and their outcomes:	
RISKS	

PROPOSED SUPPORT ARRANGEMENTS
SUPPORT - What is being requested? (details of service/support).
PLAN - Support Plan (day of week - am/pm/nighttime, etc.) with crisis management (support in place/what will happen if support is not available?)
WHY - Reason for request?
OPTIONS - What other services have been considered?
PROVIDERS Providers considered: Preferred provider and why: Care funding calculator costs (if appropriate): £
INVOLVEMENT - How has the individual/family been involved in this decision? (include best interest decision making or use of advocate and preferences noted).
OUTCOMES - What outcomes will this service/ support package deliver to the individual? (include over what period of time and the review process)
DIVERSITY - Have the individual's cultural needs been considered? If so, how they will be met by proposed intervention/ provider?
SAFETY - CQC report & safeguarding checks completed?

FINANCIAL INFORMATION		
Cost details - Current and/or proposed (per week): £		
Is this a Joint or Sole application to health? ☐ Joint ☐ Sole		
If Joint, please confirm % split proposed: %		
Has LA funding application been submitted/approved? ☐ Yes ☐ No		
CLINICAL INFORMATION		
Is this application supported by the Clinical team (Care Coordinator/ Clinical Lead/ Consultant Psychiatrist) involved in the patients care? ☐ Yes ☐ No		
NAME	**SIGNATURE**	**DATE**
Care Coordinator/ person completing form:		
Consultant Psychiatrist:		
Locality Manager:		
East Panel Representative:		
Other:		