|  |  |
| --- | --- |
| New Direct Payment Referral and Starter Form | KMBC Logo |

**Part A - General Information – To be completed by the person making the referral**

**Contact details of the person making the referral, for example a social worker:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Team name: |  | | Your name: | |  | | |
| Email |  | | Tel: |  | | Mobile: |  |
| Date of referral: |  | Type of referral: | | Adult | | Child | |

**About the client:**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Title: |  | First names(s): | |  | | | Surname | |  | |
| D.O.B |  | LAS Ref No | |  | | | Email | | / | |
| Address |  | | | | | | | | | |
| Postcode |  | | Tel: | |  | | | Mobile: |  | |
| Preferred method of contact: | | | Email | | | Telephone | | | | Mobile |

|  |
| --- |
| **Client group** |
| Select from the dropdown list: Older person |

**About the representative / parent / carer (if applicable):**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Title: |  | First names(s): | |  | | | Surname | |  | |
| Relationship: |  | | | | | | Email | |  | |
| Address |  | | | | | | | | | |
| Postcode |  | | Tel: | |  | | | Mobile: |  | |
| Preferred method of contact: | | | Email | | | Telephone | | | | Mobile |

**Contacting the client:**

|  |
| --- |
| Who will be the main contact to discuss the direct payment? |
| The client  The representative / parent / carer  Other |
|  |

|  |
| --- |
| Does the client or representative need information in an alternative format? If so, please provide details. |
|  |

|  |
| --- |
| KDC operate a safer visiting policy for lone workers. Please provide full details of any risks that may need to be taken into account in relation to lone visits to the clients home. For example accessibility, challenging behaviour, pets, general environment, key safe. |
|  |

|  |
| --- |
| **Part B – Referral form** **– To be completed by the person making the referral** |

Part B should be completed to make a referral for information and advice.

**About the assessed needs:**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| What assessed needs will the DP be used for? | Maintaining personal hygiene | | |  | Managing toilet needs | | |  |
| Being appropriately clothed | | |  | Managing and maintaining  Nutrition | | |  |
| Maintaining a habitable  home environment | | |  | Being able to make use of  your home safely | | |  |
| Developing and maintaining family or other personal relationships | | |  | Making use of necessary  facilities or services in the  local community *(including public transport, and recreational facilities or services)* | | |  |
| Accessing and engaging in  work, training, education or  volunteering | | |  | Carrying out any caring  responsibilities for a child | | |  |
| Please select the services that apply for this DP:  Please state if other: | PA (standard) |  | PA (sleep) | | |  | PA (negotiated) |  |
| Agency |  | Respite | | |  | Day care |  |
| Transport |  | Equipment | | |  | Other |  |
|  | | | | | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Who will the DP be paid to? | The client |  | A representative |  | A managed account provider\* |  |
| \*Name of managed account provider: | |  | | | | |

**Returning the form:**

|  |  |
| --- | --- |
| When part A and B are completed, this form should be sent to KDC who will contact the client or representative to make an appointment for information and advice.  Part C should only be completed when a client wants to go ahead with the Direct Payment. | |
| **Return the completed form and attachments to:**  **Andy Gilbert**  **Team Manager**  **KDC Direct Payments Support Service** | Email: andy.gilbert@kdc.org.uk |
| Telephone: 0151 480 8873 |

**Part C – Direct Payment Starter Form**

Areas in black – to be completed by KDC

Areas in red – to be completed by the person making the referral (for example, a social worker)

**About the direct payment**:

|  |  |
| --- | --- |
| Please state what has been agreed at panel (eg how many hours and type of care): | |
| 28 days respite | |
| Weekly indicative direct payment budget:  If applicable, separate term time and non-term time: |  |
| Start date:  (For Childrens Social Care, ensure DBS check returned prior to start date) |  |

**KDC to complete**

|  |  |  |
| --- | --- | --- |
| Name of PA /Agency: |  | |
| Type of account | Choose an item. | |
| Payroll Information: |  | |
| Comments: |  | |
| Provide details of the client’s employer’s liability insurance (if a PA is being employed): |  | |
| Pension being provided: | Yes | No |
| Provide details of any support to be provided, for example assisting to support a PA: |  | |

**The person dealing with the referral should complete this section**

|  |  |
| --- | --- |
| Date when DP client agreement was signed: |  |
| Confirmed start date: |  |
| Date for direct payments review (Usually 28 days after start date): |  |

|  |  |
| --- | --- |
| Has a dedicated bank account been set up? |  |
| Please provide the account details:  Sort code:  Account number:  Account holder name: |  |
| DP advisor: |  |
| First audit due: |  |