CARERS HEALTH RESPITE BREAK FUND

REPLACEMENT CARE AND ASSISTIVE TECHNOLGY (GADGETS) PROVISION

CASS
Supporting Carers to Care

PLEASE NOTE:

APPLICATIONS CANNOT BE ACCEPTED IF ALL SECTIONS ARE NOT COMPLETED

THE APPLICATION WILL BE RETURNED IF THERE ARE ANY OMISSIONS. IF YOU ARE UNSURE OF THE CRITERIA PLEASE READ THE ATTACHED LEAFLET OR CONTACT:
THE CASS BREAKS ADMINISTRATOR ON: 01785 222365

1. **All pages and sections must be completed before applications are considered.**
2. **If your application is successful, the fund must be used within 2 months of receipt and solely for the purpose requested.**
3. **Proof of expenditure will be required.**
4. **Information marked with an asterisk will be shared with South Staffs Primary Care Trust for monitoring purposes only.**
5. **Please do not book any care or make any arrangements until you have confirmation of the fund.**

CARERS DETAILS (APPLICANT):

TITLE: **MR/MRS/MISS/MS (Please delete as appropriate)**

FIRST NAME: _____

SURNAME: _____

ADDRESS: _____

_____

_____

_____

POSTCODE*: _____

TELEPHONE NO: _____

EMAIL: _____

1. What is your date of birth? _____

2. What is your age now?*

Under 18 ☐ 18 - 64 ☐ 65 – 74 ☐ 75 – 84 ☐

85 + ☐

3. How would you describe your ethnic background?*

White: British ☐ Irish ☐ Other ☐

Black or Black British: Caribbean ☐ African ☐ Other ☐

Asian or Asian British: Indian Pakistani ☐ Bangladesh ☐ Other ☐

Chinese or other ethnic background Chinese ☐ Other ☐

4. What is the name of your G.P. practice?*

_____

_____

5. How did you hear about the Carers Health Respite Break Fund?

CASS ☐ A friend ☐ Social Worker ☐

Local Press ☐ Health Professional ☐ Other ☐

6. What is the name/names of the person/people you care for?

_____

7. What is their address? (We will not contact them)

_____

_____

8. What is their date of birth?*

_____

9. What is their age now?*

Under 18 ☐ 18 - 64 ☐ 65 – 74 ☐ 75 – 84 ☐

85 + ☐

10. What relationship are they to you?*

Spouse ☐ Partner ☐ Parent/Parent in law ☐

Son/Daughter ☐ Friend ☐ Other ☐

11. What is their illness/disability?*

Learning disability ☐ Physical disability ☐

Sensory Disability ☐ Mental health needs ☐

Dementia Type illness ☐ Substance/alcohol misuse ☐

Elderly /Frail ☐

Other (Please explain) ☐ _____

_____

_____

12. What is the name of their G.P. practice?* _____

13. Are YOU registered as a family carer with the Carers Association Southern Staffordshire?

Yes ☐ No ☐ Unsure ☐

14 Have you received a Carers Health Respite Break Fund before?

Yes ☐ No ☐

If 'yes' what date were you awarded this? (approximately)

_____

15. Please explain your caring role e.g. how long you have been caring and how it affects Your life

_____

_____

_____

_____

_____

_____

_____

16. How will the HEALTH RESPITE BREAK or ASSISTIVE TECHNOLOGY (gadgets) help you as a carer?

_____

_____

_____

_____

_____

_____

17. Have you had a carers' assessment?

Yes ☐ Never ☐

18. What type of care are you applying for? (Maximum 2 sessions) – Please tick a maximum of two boxes (2 sessions) if mixed care is required.
NOTE: care costs are <u>estimated</u> at £18.00 per hour

Overnight Care	☐	Evening Care	☐
Daytime Care	☐	Assistive Tech. / Gadgets	☐

19. Total cost of care costs (maximum amount of award is £300)

_____

20. Who will provide the care?

Professional agency/worker	☐	Family member/friend	☐

(Not applicable if you are only applying for assistive technology)

21. If you are applying for assistive technology (gadgets) what is the estimated cost?

_____

What assistive technology (gadgets) are you applying for?

_____

I AGREE TO COMPLETE A RECEIPT AND SUBMIT IT TO CASS WITH THE RELEVANT EVALUATION FORM, AS REQUESTED.

Signed: _____

Date: _____

If you are successful – who would you like the cheque payable to?

_____

<u>Completed forms should be returned to:</u>

Carers Break Administrator - CASS
The Carers Centre
Austin Friars
Stafford
ST17 4AP
Telephone Number: 01785 222365

<u>PLEASE REMEMBER</u> TO ASK A PROFESSIONAL OR SUPPORT WORKER TO FILL IN THE STATEMENT OF SUPPORT (OVERLEAF) Your application will be returned if this is not completed

CARERS HEALTH RESPITE BREAK FUND

STATEMENT OF SUPPORT

This section MUST be completed by a health care professional – i.e. G.P., district or practice nurse, a social worker or a CASS staff member – who has an insight into your caring role. THE APPLICATION WILL BE RETURNED IF SUPPORTING EVIDENCE IS NOT PROVIDED.

Carers Name: _____

- **I support the above named person in their application for Carers Health Respite funding.**
- **I confirm that their caring role is regular and substantial and impacts on their own mental and physical wellbeing.**

Is there any additional information that would be useful when considering this application?

Yes ☐ **No** ☐

If 'yes', please explain: _____

_____

_____

_____

Signed: _____ **Dated:** _____

Name: (please print): _____

Designation: _____

Contact Address: _____

_____

_____

_____

Contact Number: _____