Please note – this funding is only available to subsidise the cost of a support worker for a child with additional needs

Data Protection

Hounslow Council will process information included in this document in accordance with the Data Protection Act 1998. The Council will not disclose such information to any unauthorised person or body and will only use such information for the purposes of administering your application. The information will be retained only for as long as necessary to do so and then securely destroyed. The Council may also use this data in connection with the prevention or detection of fraud or other crime.

|  |  |  |
| --- | --- | --- |
| **Name of Scheme:** | | |
| **Address of Scheme:** | | |
| **Tel No:** | **E-mail:** | |
| **Name of Play Leader:** | | |
| **Name of scheme SENCO:** | | |
| **Does your scheme receive any other additional funding for this child?**  **(If yes) Received From:** | | **Yes / No**  **Amount: £** |
| **Have parents/carers agreed to and signed this support request application?** | | **Yes / No** |

|  |  |  |
| --- | --- | --- |
| **Full Name of Child:** | | **Date of Birth:** |
| **Gender:** |  | |
| **School: Year/Class** | | |
| **Name of School SENCO and contact details:** | | |

|  |  |
| --- | --- |
| **Parent/Carer:** | **Parent/Carer:** |
| **Relationship to Child:** | **Relationship to Child:** |
| **Parental Responsibility: Yes / No** | **Parental Responsibility: Yes / No** |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Reason for Referral - (Please tick all that apply and complete box below) | | | | | | | | |
| **Attention Deficit Hyperactivity Disorder (ADHD)** | |  | |  | | |  | |
| **Autistic Spectrum Disorder (ASD)** | |  | |  | | |  | |
| **Visual Impairment** | |  | | **Hearing Impairment** | | |  | |
| **Social Skills/Interaction** | |  | | **Medication needs / Medical Conditions** | | |  | |
| **Emotional/Behaviour/Mental Health** | |  | | **Independence and personal care** | | |  | |
| **Motor skills/Co-ordination/Mobility** | |  | |  | | |  | |
| **Communication** | |  | |  | | |  | |
| **Does the child currently receive 1:1 support during or outside of the school day? Yes / No**  **If yes, please give specific details including hours per day:** | | | | | | | | |
| **Please complete the sections below giving details of the areas ticked above.**  **We will use this information to make our decision so please provide all relevant information** | | | | | | | | |
| **The specific need(s) or difficulty the child is experiencing and how this is exhibited** | **The strategies the setting has or plans to put in place, to support the child’s need(s)** | | | | **Specify how an Inclusion Worker will help to support the child’s nee(s) and enable them to be fully included in activities.** | | | |
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| **SUPPORTING INFORMATION: DO NOT SEND THIS INFORMATION UNLESS REQUESTED**  **(This information should be kept with the child’s records and available for viewing for audit purposes)** | | | | | | | | |
| **HAF Providers assessments** | |  | **Any other Reviews** | | | | |  |
| **Have you completed a Support Plan for this child?** | | | | | | **Yes / No** | | |
| **Have you completed a Risk Assessment for this child?** | | | | | | **Yes / No** | | |
| **Name of designated Inclusion Support Worker:**  \*You must ensure that the support worker has the relevant skills, experience and/or training to appropriately support this child. | | | | | | | | |

The Inclusion Grant may be allocated for: The maximum entitlement for any holiday period

* Easter: - 4 days, for 4 hours
* Over summer: - 4 weeks, which cover a maximum of 16 days, consisting of 4 hours per day
* Over Christmas: 4 days, for 4 hours
* Maximum hourly rate of £11.50 per hour

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Please indicate the sessions you are applying for 1:1 support for the child named in the application** | | | | | | | | |
|  | **Monday** | **Tuesday** | | **Wednesday** | | **Thursday** | | **Friday** |
| **Holiday Playscheme** |  |  | |  | |  | |  |
| **w/b:** |  |  | |  | |  | |  |
| **w/b:** |  |  | |  | |  | |  |
| **w/b:** |  |  | |  | |  | |  |
| **w/b:** |  |  | |  | |  | |  |
|  | | | | | | | | |
| **Provider Declaration:**  On behalf of (Name of Provider/Scheme) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   1. I understand Inclusion Grant Funding is provided by the Local Authority and is subject to eligibility, available budgets, and approval at each delivery. 2. I certify that our provision is not receiving any other funding relating to the named child 3. I understand my failure to provide complete, and truthful information on the application will be grounds to deny or withdraw the application and may affect any future funding applications made. 4. I agree that the information provided in this application may be shared with other professionals involved with the child named on the application. 5. I understand that the child’s parents must be consulted and kept informed throughout this process and for the duration of the funding 6. I confirm that the information I have provided is complete and accurate to the best of my knowledge. 7. If approved, I understand the Inclusion Grant funding is subject to the submission of a Support Plan, a Risk Management Plan   SIGNED………………………………………… PRINT FULL NAME………………………….…….…………………  DATE…………………………………………… POSITION …………………………………….………………………. | | | | | | | | |
|  | | | | | | | | |
| **Parent Declaration:**   1. I/we parent(s) of (Child’s Full Name) **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** authorise the above-named provider to make an application to the Inclusion Grant as agreed above on behalf of my/our child 2. I/we understand the Local Authority will use the information provided on this form to confirm my child’s eligibility and enable this provider to claim Inclusion Grant funding. 3. I/we acknowledge that failure to provide complete accurate and truthful information on the application will be grounds to deny or withdraw the application and may affect any future funding applications made on behalf of my/our child. 4. I/we understand that the Local Authority (LA) are bound by the Data Protection Act and will not reveal information held on my child to a third party unless the law allows them to.   SIGNED……………………………………… PRINT FULL NAME…………………………….…….…….……….……    DATE………………………………………… RELATIONSHIP TO CHILD…………………….…….….……….……. | | | | | | | | |
|  | | | | | | | | |
| **Office use only: Inclusion Granting Agreed: Yes / No** | | | | | **Referral No** | |  | |
| **Period covered from: to:** | | | **Hours:** | | | | **Cost: £** | |
| **Authorised by:** | | | **Date:** | | | | | |
| **Comments:** | | | | | | | | |