# Appendix 1 – application form for individuals

### Requests for assessments of previously unassessed periods of care from 1 April 2012

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## Introduction

This is a template application form intended to help individuals prepare for their application.

Please contact your local integrated care board for information on the process for making a request and to be sent an application form to complete.

### Guidance for completing the application form

This application form serves as a record of the request for an assessment of a previously unassessed period of care for NHS continuing healthcare (NHS CHC) from 1 April 2012. Please complete all questions in as much detail as possible.

You will have the opportunity to submit your own documents as evidence of care needs and payments for such care alongside this form.

Types of evidence which may help you to complete this form and may support the application can include:

* hospital records
* residential care home records or home care records
* GP records
* nursing records or care charts
* symptom diaries and/or daily care sheets
* care and support plans
* letters, including appointment details and discharge letters
* records from other health professionals or specialists - for example, speech and language therapists, tissue viability nurses or physiotherapists
* prescriptions
* invoices, receipts and bank statements with details of paid-for care

Please note: this list is not exhaustive. Further examples of relevant evidence can be found in Practice Guidance note 22 in the [National framework for NHS continuing healthcare and NHS-funded nursing care (2022)](https://www.gov.uk/government/publications/national-framework-for-nhs-continuing-healthcare-and-nhs-funded-nursing-care).

If you would benefit from support or advice with completing this form, please consider speaking with a health or social care professional, or someone who knows about your care needs or health situation.

## Application form

### Personal details of the individual this request is for

|  |  |
| --- | --- |
| Full name |  |
| Date of birth |  |
| Date of death, if applicable |  |
| Home address | If the individual is now resident in a care home, please also provide their home address prior to moving: |
| Address of care homes, if applicable | Please give the details of all care homes the individual has lived in during the time period being considered:Name and address of care home 1:From (DD/MM/YYYY):To (DD/MM/YYYY):Name and address of care home 2:From (DD/MM/YYYY):To (DD/MM/YYYY):If you require additional space, please continue answers on separate paper. |
| NHS number |  |
| Name and address of GP that individual was registered with immediately prior to period of care to be considered |  |
| Dates you are requesting for assessment of a past period of care |  |

### Information about the individual's needs and assessment history

Please complete the following as fully as possible. If you require additional space, please continue answers on separate paper.

Were any of the following assessments undertaken? (Please delete as appropriate.)

NHS continuing healthcare checklist Yes/No/Unsure

NHS continuing healthcare decision support tool Yes/No/Unsure

NHS-funded nursing care assessment Yes/No/Unsure

If yes, please provide the relevant dates:

|  |
| --- |
|  |

Was the individual in hospital immediately prior to the period you are asking to be assessed? If so, which hospital? Please include a summary of the relevant treatment history and admissions/discharges from hospital.

|  |
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During the review period, was the individual seeing any health professionals - for example, a medical consultant, community psychiatric nurse, district nurse, speech and language therapist, tissue viability nurse or others? If so, please provide a summary of details below including which professionals, frequency of appointments, when they were first referred, and whether they have been discharged.

|  |
| --- |
|  |

Please provide a summary of the care needs of the individual for the claim period. For detailed description of these needs, individuals can consult the [decision support tool (DST) form](https://www.gov.uk/government/publications/nhs-continuing-healthcare-decision-support-tool) - [NHS continuing healthcare decision support tool on GOV.UK](https://www.gov.uk/government/publications/nhs-continuing-healthcare-decision-support-tool). You may wish to consider the following:

|  |  |  |
| --- | --- | --- |
| Breathing | Mobility | Behaviour |
| Nutrition and/or food and drink | Communication | Medication and/or drug therapies, including symptom control |
| Continence needs | Psychological and emotional needs | Altered states of consciousness |
| Skin and/or tissue viability | Cognition | Any other significant care needs |

|  |
| --- |
|  |

Please list below any existing evidence which you think may help support your claim and which you intend to forward with this application. Any existing evidence of the individual’s care needs relevant to the claim period should be submitted along with this application form. This could include GP records or any other records detailing care provided to the individual during the claim period. This evidence may help to speed up the assessment process.

|  |
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|  |

Please list below any existing evidence that the individual paid for their care which you think may help support your claim and which you intend to forward with this application. Any existing evidence of payments relevant to the claim period should be submitted alongside this application form. This could include receipts and/or bank statements. This evidence might help to speed up the reimbursement process (if applicable).

|  |
| --- |
|  |

### Personal details of the individual completing this application

|  |  |
| --- | --- |
| Full name |  |
| Home address |  |
| Relationship to the individual this request is for, if applicable |  |
| Telephone number |  |
| Mobile number |  |
| Email address |  |

### Submission

Please sign and date this application form

Name…………………………………………………………………………………………………

Signature……………………………………………………………………………………………

Date (DD/MM/YYYY)……………………………………………………………………………………

1. You may also be required to complete a consent form and provide proof of your authority to make this claim.
2. Please return the following documents to us as soon as possible and no later than 28 days from the date this form was sent to you:
	* this application form
	* consent form (if applicable)
	* authority documents (if applicable)
	* evidence of care needs and payments for care received

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