**North East Lincolnshire Council**

**Early Years Inclusion Fund Application**

**Individual Request**

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| **Child:** |  |
| **School / Setting:** |  |

Completed applications should be returned by secure email to [earlyyearsnelc@nelincs.gov.uk](mailto:earlyyearsnelc@nelincs.gov.uk)



**Request for INDIVIDUAL Early Years Inclusion Funding**

**Request for Inclusion funding for children from birth to school entry (4 years of age) with SEND and or complex medical needs.**

Most children’s needs should be met through universal provision, their key worker and small group intervention work. For children with significant and complex needs Inclusion funding can be used to support them within your provision.

Before making an application, please refer to the Inclusion Funding guidance notes and checklist of evidence.

If a child attends more than one setting a joint application should be made at the same time to ensure equity of funding.

If you are completing the settings form, please note the same children **CANNOT** be put on the individual form.

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| **Basic Information** | | | | | |
| Name of Child: |  | | Date of Birth:  Age in months: | |  |
| Address: |  | | | | |
| Parental Responsibility (name): |  | | Relationship to the child: | |  |
| Email Address: |  | | | | |
| Gender: |  | |  | |  |
| First Language: |  | | Ethnicity: | |  |
| GP name and address (& NHS number if known) |  | | | | |
| Hours attending EY setting: |  | | Hours the child is entitled to: | |  |
| Percentage of eligible sessions attended during the last term: |  | | How many hours are you requesting for EYIF support? | |  |
| Details of previous EYIF funding: | Amount requested: | | EYIF CYCLE:  (Please highlight & date when each cycle begins) | | Cycle 1  Cycle 2  Cycle 3  Final Review |
| Amount granted: | |
|  |  | |  | |  |
|  |  | |  | |  |
| **Current Assessment (e.g. Birth to 5 / Dev Matters)** | | | | **Date:** |  |
| **CLL** | | **PSED** | | **PD** | |
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| **Suggested Primary Need:**  **Please tick the box below where you feel the child has most difficulties.** | | | | **Date:** |  |  |
| **Communication and Language** | | **Sensory and/or Physical Needs** | | **Cognition and learning** | | **Social, emotional, and mental health difficulties** |
| Social communication difficulties | Speaking and listening | Sensory | Physical |  | |  |

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| **Setting Information** | | | |
| Name of Setting |  | | |
| Address: |  | | |
| SENCO name: |  | Key worker name: |  |
| Name & Email to which the decision letter will be forwarded: |  | | |
| Telephone: |  | | |
| Are Early Help Involved?  Currently: Yes/No  Previously (date) | | Is this child looked after?  Yes/No | |
| Child in Need? | | | Yes/No |
| Child Protection Plan? | | | Yes/No |

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|  | **Currently** | **In the process:** |
| Two-year-old funding | N | N |
| Eligible for extended hours (30 hrs) | N | N |
| An Education Health and Care Plan | N | N |
| DLA (Disability Living Allowance) | N | N |
| DAF (Disability Access Fund) date paid: | N | N |
| A referral made to Access Pathway (report to be included) | Yes/No Date: | Date:  Agreed: Yes/No |
|  | **Yes/No (List)** | **Date: May 23** |
| Have speech and language interventions been implemented e.g WELLCOMM, Language through Listening, other |  |  |
| WELLCOMM screening outcome: |  |  |
| A referral made to SALT   * Children’s centre * NHS |  |  |
| Does the child have: | Hearing loss: Yes/No | Vision loss Yes/No |
| Does the child have hearing aids? Yes/No  Does the child have a cochlear implant? Yes/No | Are Ophthalmology/Orthoptist involved? Yes/No |
| Please List any other agencies involved e.g. Portage, Occupational Therapy etc: |  | |

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| **Additional resource required e.g. equipment, training, enhanced ratio** | **Cost** |
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|  |  |
|  |  |
|  |  |
| Total: |  |

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| Child’s Family- strengths and needs |
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| Child and Parent’s views and aspirations: |
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| These are the things that are working well for me at the moment: |
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| These are the things that are not working well for me at the moment: |
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**What level of support is being provided?** Please indicate the level of support **by adding the date** that this level was started or reviewed:

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|  | **Setting Support (reasonable adjustments)** | **Specialist support**  **(Who and attach any relevant reports)** |
| **Communication and Interaction** |  |  |
| **Cognition and Learning** |  |
| **Social, Emotional and Mental Health Needs** |  |
| **Physical and Sensory Needs including Hearing Impairment, Visual Impairment and Multi-Sensory Impairment** |  |
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Information should:

* be clear and specific;
* describe the needs of the child;
* describe the provision that may be required to meet needs;
* describe the outcomes that are intended to be achieved by the child receiving that provision;

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| **Outcome Number** | **Intended Outcomes – what is the child intended to achieve?** | **Intended provision- be specific, what is needed to meet the outcome?** | | **How often and for how long?** | **Who will provide this support? (named post/person/people and agency)** | **Achieved/Not Achieved** |
| **Communication and Interaction** | | | | | |  |
| 1. |  |  | |  |  |  |
| 2. |  |  | |  |  |  |
| 3. |  |  | |  |  |  |
| **Cognition and Learning** | | | | | | |
| 1. |  |  | |  |  |  |
| 2. |  |  | |  |  |  |
| 3. |  |  | |  |  |  |
| **Social, Emotional and Mental Health** | | | | | | |
| 1. |  |  | |  |  |  |
| 2. |  |  | |  |  |  |
| 3. |  |  | |  |  |  |
| **Physical and or Sensory** | | | | | | |
| 1. |  |  | |  |  |  |
| 2. |  |  | |  |  |  |
| 3. |  |  | |  |  |  |
| **Independence** | | | | | | |
| 1. |  |  |  | |  |  |
| 2. |  |  |  | |  |  |
| 3. |  |  |  | |  |  |

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| **Date plan submitted:** |
| **Declaration:**  This grant will be used to provide additional resources to facilitate the inclusion of the above-named child in our setting. We understand the requirement to review the impact on the child’s progress towards the Outcomes identified in the Plan and that the money may be ceased if these conditions are breached. |
| **Signed: Date:**  **Name: Designation:** |
| **Parent/Carer name:**  **Signed: Date:** |

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| **Checklist** | **Included** | **Explanation if not included** |
| **Early Help Assessment/Plan/Access Pathway Referral/Plan** |  |  |
| **My Plan/Weekly evidence sheets** |  |  |
| **2yr Progress Check (within last 6m)** |  |  |
| **ASQ.SE/ ELIM/WELLCOMM** |  |  |
| **Tracking/Assessments** |  |  |
| **Specialist health Reports/Recommendations E.G Physio, OT, SLT, Paediatrics.**  **Specialist Educational Reports/Recommendations E.G EP, Area SENDCos, CDC** |  |  |
| **Other (E.G Social Care)** |  |  |