Mental Health Services
Hospital No:

CPA/Care Management
Client Reference No:

(TO BE COMPLETED BY SOCIAL WORKER OR CARE MANAGER)

Request for Finance

Clients Name:	**DOB:**	
Application of Eligibility Criteria **Category One** • **Anyone whose physical, mental or emotional problems mean they are a risk to themselves or others** • **Anyone whose physical, mental or emotional state would markedly worsen, or who would need residential care, without immediate help** • **Anyone faced with immediate severe problems because of family breakdown** • **Children whose development has been seriously imparied by abuse, neglet or lack of stimulation** • **Anyone who is dependent on alcohol or drugs and wants help in tackling this problem** **Category Two** • **Anyone who may become a risk to themselves or others if they do not get help.** • **Anyone whose independence is greatly reduced because they are ill, are about to leave hospital, or have a physical, mental or emotional difficulties.** • **Anyone who has social or emotional problems caused by such factors as a major upheaval in their ife, addiction, isolation, or lack of stimulation.** **Category Three** • **Anyone who is not at risk, nor having severe difficulties, but whose ability to cope would be increased if they had help.** • **Anyone for whom help would prevent any difficulties getting worse.**		**Comments:**

	Name	Signature
You (as service user)	.....	.....
Carer/Representative	.....	.....
Care Manager	.....	.....
Budget Holder	.....	.....

NATURE OF REQUEST

What	Period (from/to)	Cost (per week/month/one off	Max. Total Cost	Provider Name and Address for Payment	Finance Action Completed

Total Cost of this Request