OFFICIAL - SENSITIVE

EYSFFv3form

Directorate of Children's Services
Schools and Learning Division

Early Years Special Educational Needs Funding Request Form (To be used for Additional Support and/or Equipment)

To be completed by the Early Years Education Provider

Child Details (please print):					
Full Name:			**Male:**		**Female:**	
Date of Birth:		**Ethnic Origin:**			
Address:					

Funding Required For: **(please (✓) select one option only)**

Additional Funding:		**Specialist Equipment:**	

Main Areas of Need: (please (✓) select one option only)

Communication and Language:		**Cognition and Learning:**	
Physical Development:		**Personal/Social/Emotional Development:**	
Visual Impairment:		**Hearing Impairment:**	
Significant Behaviour Impacting on Access to the Curriculum:			

Early Years Provider/Setting Details (please print):						
Provider/Setting Name & Address:						
Telephone Number:						
Email Address:						
Manager/Supervisor: (full name)						
SENCO: (full name)						
Key Worker: (full name)						
Child's Admission Date:						
Days/Hours Child Attends:	**Monday**		**Tuesday**		**Wednesday**	
	Thursday		**Friday**		**TOTAL**	

Is the child in receipt of Two Year Funding?	Yes:		No:	
Is the child eligible for 30 hours funding?	Yes:		No:	
Is the child stretching their entitlement to cover the holidays?	Yes:		No:	

Early Years Involvement (please print):	
Early Years SEN Advisor (Inclusion):	
Early Years SEN Advisor (Portage):	

Name of professionals Involved		Date of referral and advice given? Please provide evidence.
Barnardo's:		
Paediatrician:		
Health Visitor:		
Speech & Language Therapist:		
Physiotherapist:		
Occupational Therapist:		
Social Care: (CAF in place?)		
Others:		

Details of the child's disability/needs including any diagnosis:

Evidence of strategies already in place to support the child's needs and the impact on the child. This must be a minimum of two Plan Do Review cycles: (please use a separate sheet if necessary)	
Strategy:	Impact/Outcome:

Proposed Action Plan/Targets for child if additional funding is granted. How will the funding support the child's progression in the EYFS curriculum?: (please use a separate sheet if necessary)	
Action/Targets/ required:	**Desired Outcome:**

Is the Child in receipt of Disability Access Funding?	
How has this funding been used to support the child in the setting?	

Hours being requested:				
Total number of hours per week being requested:				
Start date funding required from:				
Duration (if known):				
Please enter the hours being requested in boxes below:				
Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**

Details of equipment required as recommended by the Occupational Therapist etc: (Please attach a copy of the quote)

- **Please include evidence of diagnosis, medical reports, plan do and review documentation for your application to be considered.**
- **If funding is agreed and required for a second term this will need to be reapplied for with updated information showing progress made.**
- **After two terms of funding an Education Health and Care plan must be requested for funding to continue.**

Parent/Carer Details (please print):					
Title:		First Name:		Last Name:	
Parent/Carer Signature:					
Home Telephone:	(01983)		Mobile Number:		
Email Address: (must be included)					

Signed: **Print Name:**

Designation: **Date:**

Please return the completed form electronically to: pupil.services@iow.gov.uk

The Isle of Wight Council complies with the Data Protection Act 1998. By registering these details I understand that the information will be held securely on the Isle of Wight Council's databases for the purpose of recording the support provided to my child and family. I give consent for information to be shared with children's centres, professionals and other agencies as appropriate.