

Supporting SEND families with a helping hand

1. General information: Names and your position

Your name:

Your email address:

Your phone number:

The child/young person's name:

Gender: Male Female Other:

Age:

2. About the child/young person: diagnoses and needs

What are the diagnoses, or possible diagnoses and needs of the child/young person? (This list is not exhaustive and merely represents the common diagnosis we support)

- | | |
|---|--|
| <input type="checkbox"/> ASD (autism) | <input type="checkbox"/> Gender Dysphoria |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Global Development Delay |
| <input type="checkbox"/> Blind or visually impaired | <input type="checkbox"/> Gross Motor Delay |
| <input type="checkbox"/> Brain injury (Traumatic or acquired) | <input type="checkbox"/> Heart conditions |
| <input type="checkbox"/> Breathing difficulties (Asthma, chronic lung disease)) | <input type="checkbox"/> Non-speaking (Non-verbal) |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Obsessive-Compulsive Disorder (OCD) |
| <input type="checkbox"/> Complex medical needs | <input type="checkbox"/> Other genetic mutation |
| <input type="checkbox"/> Challenging behaviour | <input type="checkbox"/> Oxygen dependence and Tracheostomies |
| <input type="checkbox"/> Childhood cancer | <input type="checkbox"/> Psychological Disorders (other) |
| <input type="checkbox"/> Chromosome deletion | <input type="checkbox"/> Rare genetic Disorders and mutations (Other) |
| <input type="checkbox"/> DCD (dyspraxia) | <input type="checkbox"/> SEMH/mental health needs |
| <input type="checkbox"/> Deafness or hearing impaired | <input type="checkbox"/> Sensory and/or auditory processing needs |
| <input type="checkbox"/> Downs syndrome | <input type="checkbox"/> Sickle Cell disease |
| <input type="checkbox"/> Duchenne muscular dystrophy (DMD) | <input type="checkbox"/> Speech and Language needs |
| <input type="checkbox"/> Dyscalculia | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Dyslexia | <input type="checkbox"/> Spinal Muscular Atrophy (SMA) |
| <input type="checkbox"/> Eating disorder(s) | <input type="checkbox"/> Stoma /Colostomy care |
| <input type="checkbox"/> Encephalitis | <input type="checkbox"/> Tube fed and/or NBM (NJ, NG, PEG, RIG, JEJ, PEG J |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Working memory difficulties |
| <input type="checkbox"/> Executive Functioning Skills/Study Skills | <input type="checkbox"/> Awaiting specific diagnosis |
| <input type="checkbox"/> Fetal Alcohol Syndrome | <input type="checkbox"/> Does not have a diagnosis |

Please provide an overview of the child/young persons needs i.e any diagnosis not listed above, detail of needs and any additional information you feel may be necessary.

3. Assistance requirements

The young person:

- | | |
|--|--|
| <input type="checkbox"/> Requires mobility/positioning | <input type="checkbox"/> Requires sleep support |
| <input type="checkbox"/> Requires adaptive physical equipment | <input type="checkbox"/> Requires medication |
| <input type="checkbox"/> Is non-verbal | <input type="checkbox"/> Requires feeding/nutrition support |
| <input type="checkbox"/> Is pre-verbal | <input type="checkbox"/> Requires support with additional therapies |
| <input type="checkbox"/> Can communicate needs verbally | <input type="checkbox"/> Requires medical care |
| <input type="checkbox"/> Can communicate using visual systems | <input type="checkbox"/> Requires medical equipment |
| <input type="checkbox"/> Requires adaptive technology for learning | <input type="checkbox"/> Requires uninterrupted medical care and supervision (1:1) |
| <input type="checkbox"/> Requires adaptive technology for sight | <input type="checkbox"/> Requires in excess of 1:1 supervision |
| <input type="checkbox"/> Requires adaptive technology for hearing | <input type="checkbox"/> Requires Team Teach/Restraint |
| <input type="checkbox"/> Requires continence care | <input type="checkbox"/> Requires additional safety measures |
| <input type="checkbox"/> Requires toileting assistance | |

Please provide us with any additional requirements not listed above and/or provide more information about the requirements you have your selected.

Are there any behavioural triggers or safeguarding concerns regarding the child/young person that the Helping Hand should be aware of?

Are there any other areas regarding safety and wellbeing of the Helping Hands or child/young person that are not covered above?

- No, I have mentioned all health and safety considerations above
- Yes, I would like to mention that....

4. Education status and needs

Does the child/young person attend school or college?

- Yes, the young person attends school or college
- Yes, the young person has a named school or college, but does not physically attend
- Yes, the young person has a named school or college, and is due to leave (Post 16+)
- No, the young person does NOT attend school or college and does not have a named provision
- Other (Please give details if the young person is homeschooled, excluded, awaiting placement or out of school for medical reasons such as a prolonged hospital admission)

Name of school or college:

School year:

Type of school or college:

- | | |
|---|---|
| <input type="checkbox"/> Mainstream state school or college | <input type="checkbox"/> Mainstream independent school or college |
| <input type="checkbox"/> Specialist school or college | <input type="checkbox"/> Specialist independent school or college |
| <input type="checkbox"/> Alternative provision | |

Other:

* Please complete this section if you are requiring [educational support](#) such as a Tutor **

What are the child/young person's main areas of needs? What subjects or areas of special educational needs do they need support with? You can provide diagnosis and needs as well as attach relevant educational reports such as their working level alongside this form.

5. Hobbies and interests

Please provide information on the child/young persons interests, hobbies and treasured personal items that may assist them in their day to day.

8. Is the child/young person receiving similar support from any other professional personnel or agency?

- Yes, with an agency. Add name here:
- Yes, with a private individual
- No

Additional information:

7. Is the child/young person currently receiving any other specialist support?

Please provide information on any other support or therapies the child is receiving such as Speech and Language Therapy , Occupational Therapy or Physiotherapy etc; either private, through the LA or NHS

8. Support requirements

- | | | | | |
|----------------------------------|------------------------------------|------------------------------------|---|--|
| <input type="checkbox"/> Tutor | <input type="checkbox"/> Monday | <input type="checkbox"/> AM | <input type="checkbox"/> At home | <input type="checkbox"/> UK |
| <input type="checkbox"/> Sitter | <input type="checkbox"/> Tuesday | <input type="checkbox"/> Afternoon | <input type="checkbox"/> In the community | <input type="checkbox"/> International |
| <input type="checkbox"/> Carer | <input type="checkbox"/> Wednesday | <input type="checkbox"/> PM | <input type="checkbox"/> Support within education provision | <input type="checkbox"/> Travel |
| <input type="checkbox"/> Nanny | <input type="checkbox"/> Thursday | <input type="checkbox"/> 24 hours | <input type="checkbox"/> Within hospital | |
| <input type="checkbox"/> Respite | <input type="checkbox"/> Friday | | <input type="checkbox"/> Other | |
| | <input type="checkbox"/> Saturday | | | |
| | <input type="checkbox"/> Sunday | | | |

- I will be supervising the support (specifically applicable with Tutoring and Caring)
- I require the support to be without supervision from myself or appropriate adult of the child/young person

Please provide more information on the support you require, specifically if you require a mixture of support services on a regular basis. You can give an example of a regular week or monthly time table and where the support is needed.

9. Support preferences

Are there any specific requirements such as qualifications, years experience or spoken languages you require your chosen Helping Hand to have?

For example, you may require a Tutor, specifically a Dyslexia Intervention Tutor only, a Carer who has experience in ventilation care, or respite services which support challenging behaviour. This is important for us to know to help us find your perfect Helping Hand(s).

10. Support timetable

There is a booking minimum of 2 hours per support session.

Please outline below how many hours you require per week or month, this may be a single support service such as our Sitting service for 4 hours every two weeks, Respite for 12 hours once per month or a mixture of support such as 15 hours of Tutoring and 8 hours of Care.

11. Support integration

If you currently have support in your home such as a tutor, carer, or nanny etc please give details below, specifically you are seeking support with the intention of job sharing in the home.

12. Support+

If you are seeking support for a looked after child/young person please provide any relevant information here

13. Health, Safety and Safeguarding

Are there any health and safety concerns at the location where the support will take place? If so, what steps have you put in place to control or remove these risks?

Not applicable, there are no health and safety concerns or issues

Mention any health and safety concerns or issues here:

Are there any other areas regarding safety and wellbeing of the tutors or young person that are not covered above?

No, I have mentioned all health and safety considerations above

Yes, I would like to mention that....

14. Responsible adults

Who would you like to nominate anyone other than yourself as the responsible adult supervising support? This person will also deliver first-aid to the child, if necessary.*

Myself

Name of the nominated adult

Relationship to child:

Phone number:

Email address:

Please provide any additional information:

15. Next of kin/Emergency contact

Please confirm next of kin and emergency contact details here:

Name of the nominated adult

Relationship to child:

Phone number:

Email address:

Name of the nominated adult

Relationship to child:

Phone number:

Email address:

16. Start date

When would you like you support to start?

As soon as possible

On/in (mention month or date):

When funding is approved, approximately:

Other:

17. Funding

You can make payment privately, through a continued healthcare plan budget or EOTAS package provided through the LA, via personal budget, direct payments or from other sources. You may select more than one option.

Private: Name if different from above:

Continued Healthcare plan/Personal Health Budget: Name of Trust:

Direct Payment

Notional budget

Agreed real budget

EOTAS package : Local Authority:

School or college. Name if different from above:

Local authority; personal budget. Name of Local Authority:

Local authority; commissioned directly by the LA. Name of Local Authority:

Direct Payment

Notional budget

Managed accounts

Funding has been agreed and confirmed

This is continued support

This is interim support

Further information or details:

18. Budget

Do you have a budget in mind? Note: all specialist Helping Hands are self-employed and therefore set their own rate per hour

No, I am looking for the best match for the child/young person

Yes, my budget is £ per hour

Please provide any further information surrounding your budget, this may be relevant if you are requiring more than one service.

19. Costs and payments

All Helping Hands are self-employed and therefore set their own rates per hour, which is outlined on each Helping Hands individual profile.

The total cost shown on your invoice includes the services supplied to you via your chosen Helping Hand, SEND Helping Hands Ltd introductory fee and in most cases also includes travel expenses, resources, feedback, report writing/shift documentation and assessments from your chosen Helping Hand(s) unless specified otherwise.

We operate a transparent split payment system. At the end of each calendar month, you will receive an invoice directly from your chosen Helping Hand; this will consist of the services provided for that calendar month by your chosen Helping Hand. A separate invoice will be provided by SEND Helping Hands Ltd covering the introductory fee.

Your monthly invoice will be a total of the hourly service(s) provided by your chosen Helping Hand (80% of total invoice) and SEND Helping Hand Ltd introductory fee (20% of total invoice). Two separate payments will need to be made to SEND Helping Hands Ltd and your chosen Helping Hand.

I understand and agree

20. Agreement to share this booking form

I agree that SEND Helping Hands Ltd can share this completed booking form with any Helping Hands that I wish to be introduced to. This includes all contact information and information about the child/young person.*

I agree that this support request form will be used to generate a profile for the child/young person which can be provided to the Helping Hand(s) to aid familiarity between the child and chosen Helping Hand by the applicant (yourself) and/or SEND Helping Hands Ltd. I will receive a copy of the child/young persons profile for reference.

I agree that SEND Helping Hands Ltd will provide support staff (known as Helping Hands) profiles to me by way of introduction for my consideration. SEND Helping Hands Ltd will provide support amongst the interview processes with which all work will be commissioned through SEND Helping Hands Ltd.

21. Any other details or information that will help us with the matching process:

22. Finally, please complete the below: *

Signed:

Date:

How did you hear about us?

If you found us via an online search platform e.g. Google search, what did you search for?

Thank you for completing this form.

Please send your completed form to: onboarding@sendhelpinghands.com

SEND Helping Hands Ltd. Company
registration number: 16347476