

**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:	
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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	

OFFICIAL - SENSITIVE

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:

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**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.