**JOINT RESOURCES ALLOCATION PANEL**

**JRAP Change Form (4)**

**This form must be completed for any changes of costs to existing JRAP Placements e.g. increase in number of weeks of provision, a change to core costs, additional costs etc.**

***NB: If the CYP has moved units or changed providers a NEW Alert (1) form will need to be completed and emailed to*** ***admin.jrap@kent.gov.uk******.***

**Child / Young Person’s Details**

|  |  |  |
| --- | --- | --- |
| *Forename* | *Surname* | *Date of Birth* |
|       |       |       |

**Details of Current Placement**

|  |  |  |
| --- | --- | --- |
| *Provider* |  | *Placement Address* |
|       |  |       |

|  |
| --- |
| **Outline Proposed Changes** e.g. transport, 1:1 staffing, 38 week extended to 52 weeks |
|       |

**Total weekly cost of placement/provision and breakdown of cost for each agency and any additional costs/weeks including proposed changes**

**MAIN PLACEMENT**

|  |  |  |
| --- | --- | --- |
| *Number of Weeks* |  | *Annual Cost* |
|       |  |       |
| *Weekly Fee* |  | *Additional Costs e.g. transport, assessment* |
|       |  |       |
| *Social Care Weekly Fee* |  | *Social Care %* |
|       |  |       |
| *Health Weekly Fee* |  | *Health %* |
|       |  |       |
| *Education Weekly Fee* |  | *Education %* |
|       |  |       |

**ADDITIONAL WEEKS**

|  |  |  |
| --- | --- | --- |
| *Number of Weeks* |  | *Annual Cost* |
|       |  |       |
| *Weekly Fee* |  | *Additional Costs e.g. transport, assessment* |
|       |  |       |
| *Social Care Weekly Fee* |  | *Social Care %* |
|       |  |       |
| *Health Weekly Fee* |  | *Health %* |
|       |  |       |
| *Education Weekly Fee* |  | *Education %* |
|       |  |       |

**ADDITIONAL WEEKS /COSTS**

|  |  |  |
| --- | --- | --- |
| *Number of Weeks* |  | *Annual Cost* |
|       |  |       |
| *Weekly Fee* |  | *Additional Costs e.g. transport, assessment* |
|       |  |       |
| *Social Care Weekly Fee* |  | *Social Care %* |
|       |  |       |
| *Health Weekly Fee* |  | *Health %* |
|       |  |       |
| *Education Weekly Fee* |  | *Education %* |
|       |  |       |

**Lead Professionals Details**

**Social Care**

|  |  |  |
| --- | --- | --- |
| *Social Worker* | *Address* | *Team* |
|  |  |  |

|  |  |  |
| --- | --- | --- |
| *Manager* | *Email Address* | *Direct Line* |
|       |       |       |

**Health**

|  |  |  |  |
| --- | --- | --- | --- |
| *Health Lead*  | *Role* | *Address* | *Team* |
|  |  |  |  |

|  |  |  |
| --- | --- | --- |
| *Manager* | *Email Address* | *Direct Line* |
|       |       |       |

|  |  |  |
| --- | --- | --- |
| *CCG*  |  |  |
|  |

|  |
| --- |
|  |

**Education**

|  |  |  |  |
| --- | --- | --- | --- |
| *EHC / SEN Lead* | *Role* | *Address* | *Team* |
|  |  |  |  |

|  |  |  |
| --- | --- | --- |
| *Manager* | *Email Address* | *Direct Line* |
|  |  |  |

**Authorising Officer (Evidence)**

*Provide confirmation that the respective Health, Education and SCS agency panels have approved the placement and funding required*

**Health**

|  |  |  |  |
| --- | --- | --- | --- |
| *Panel Name* | *Date of panel* | *Approved by:**Name and Title* | *Date of agreement* |
|       |       |       |       |

**Education**

|  |  |  |  |
| --- | --- | --- | --- |
| *Panel Name* | *Date of panel* | *Approved by:**Name and Title* | *Date of agreement* |
|       |       |       |       |

**Social Care**

|  |  |  |  |
| --- | --- | --- | --- |
| *Panel Name* | *Date of panel* | *Approved by:**Name and Title* | *Date of agreement* |
|       |       |       |       |