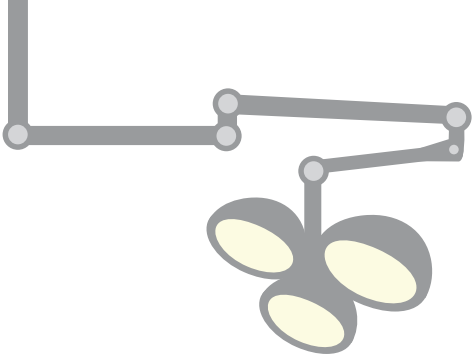


cdh UK The Congenital Diaphragmatic Hernia Charity

Home 2 Hospital Scheme

GUIDANCE INFORMATION

The scheme is for any person who has been diagnosed with Congenital Diaphragmatic Hernia and reimburses the applicant with travelling and parking costs to and from hospital appointments and for hospital stays from the point of diagnosis up until discharge from hospital to a maximum of six months after the birth of their child or six months after the diagnosis in the case of those children or adults diagnosed after birth.

In special circumstances where all other avenues of assistance have been sought, subject to criteria and at the discretion of the governing committee, we will consider the following:

- Accommodation costs. An example of this is if the applicant has undergone the FETO procedure.

In order for an application to be considered the applicant must:

- Complete the Home 2 Hospital scheme form in full and as accurately as possible.
- Include all original receipts, or proof of travel and/or parking.
- Obtain a signature from a medical professional responsible for your care or your child's care.
- Record on the application all dates of hospital appointments and/or visits and stays, which must be verified by a medical professional responsible for the care of the patient.

The applicant must be one of the following:

- The patient.
- A family member or next of kin.
- Carer or legal guardian.

IMPORTANT: Only one claim per patient is allowed to a maximum claim of £1000 inclusive of agreed additions such as accommodation.

Please ensure that you take copies of all receipts and/or proof in the event of your application not being received by CDH UK.

Name of patient:

Address of patient:

Name of applicant:

Address of applicant (if different to above):

Telephone number of applicant:

Email of applicant:

Please tick the box that describes your relation to the patient:

PARENT ☐ LEGAL GUARDIAN ☐

CARER ☐ OTHER (STATE BELOW) ☐

Other:

Patient date of birth:

Applicant's signature: Date:

ABOUT YOUR CARE

The hospital involved with the patients care:

Name of consultants:

What are you claiming for? (Tick all that apply):

TRAVELLING ☐ PARKING ☐

ACCOMODATION* ☐

The total amount of claim £

* PLEASE SEE GUIDANCE INFORMATION OUTLINED ON PAGE 1

I confirm that (name of medical staff) have been involved in the care of the patient named on this form in the capacity of (job title)

Applicant's signature: Date:

IMPORTANT: If you have used a motor vehicle, including motorcycle to attend appointments or visits DO NOT send in any fuel receipts. This mode of transport is reimbursed by a mileage allowance of a set amount per mile travelled (see website for current rate). Please use the attached proof of attendance form to tell us about the mileage you have travelled. If you do not provide us with this information, we will be unable to go ahead with your application.

Before sending in this form, please check that you have done the following:

- Completed the form in full.
- Had the form signed by a medical professional.
- Included your receipts including parking tickets, transport tickets/receipts, for example train or bus tickets.
- Completed your proof of visit form, including your mileage if you travelled to and from appointments/ visits using a motor vehicle or motorcycle.

Remember if anything is missing we will be unable to proceed with your application further.

MILEAGE RECORD SHEET

Name of patient:

Address of patient:

Name of applicant:

Address of applicant (if different to address of patient):

Telephone number of applicant:

Email of applicant:

	Date travelled	Hospital appointment (please tick)	Hospital visit (please tick)	Name of Hospital/Clinic	Miles from home to hospital/clinic	Miles from hospital/clinic to home	Name of Medical staff personnel	Position	Signature
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
				TOTAL MILEAGE TRAVELLED			Applicant's signature - declaring true & accurate confirmation of mileage:		

FOR OFFICIAL USE ONLY

Formed checked by: Are all original receipts included? Yes No Passed to committee for approval? Yes No

Claim accepted? Yes No If declined please state why: Amount reimbursed: £

Method of reimbursment: Cheque Bank transfer Cheque no. Signature: Date:

MILEAGE RECORD SHEET (continued)

Name of patient:

Address of patient:

Name of applicant:

Address of applicant (if different to address of patient):

Telephone number of applicant:

Email of applicant:

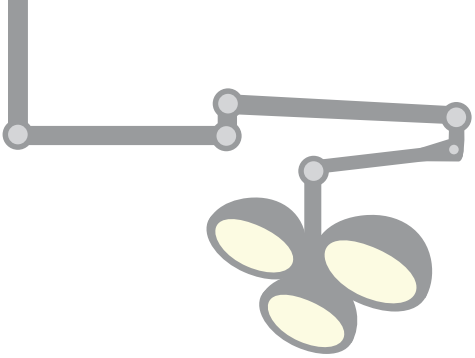
	Date travelled	Hospital appointment (please tick)	Hospital visit (please tick)	Name of Hospital/Clinic	Miles from home to hospital/clinic	Miles from hospital/clinic to home	Name of Medical staff personnel	Position	Signature
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
	TOTAL MILEAGE TRAVELLED (INCLUDING MILEAGE FROM THE PREVIOUS PAGE)						Applicant's signature - declaring true & accurate confirmation of mileage:		

FOR OFFICIAL USE ONLY

Formed checked by: Are all original receipts included? Yes No Passed to committee for approval? Yes No

Claim accepted? Yes No If declined please state why: Amount reimbursed: £

Method of reimbursment: Cheque Bank transfer Cheque no. Signature: Date:



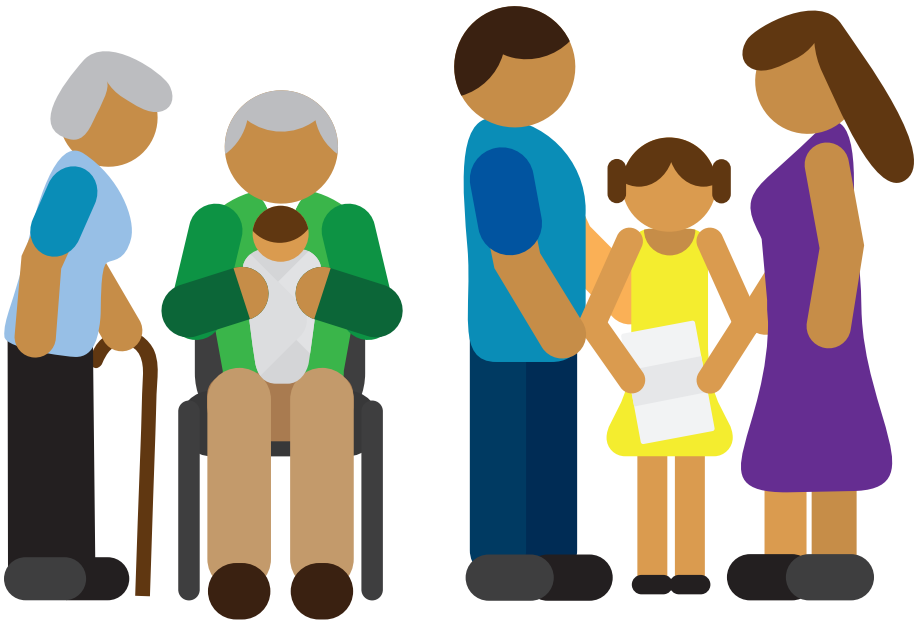
cdh UK The Congenital Diaphragmatic Hernia Charity

Home 2 Hospital Scheme

GUIDANCE INFORMATION

What are your bank details?

Account name	
Sort code	
Account number	
Signature of applicant	
Date	



Please complete this form in full and return to CDH UK.
Please note that all of the information provided will be treated with the strictest confidence and will comply with the GDPR 2018.

We are asking for this information to allow us to make an informed decision about your application. We may need to share this information with others involved in the care of the patient in order to obtain this information. This form and it's data will be stored securely for application purposes and for paying the grant to the applicant. It will then be stored for accounting and auditing purposes for a maximum of 6 years, after which it will be safely disposed. By signing this form you are agreeing to the retaining of this information for a maximum of 6 years after which we will write to you to request your permission to store it for longer if needed. This information will not be used for marketing purposes or any other purpose other than that which is stated.

☐ I have read the above statement and understand that I can email committee@cdhuk.org.uk anytime to request that my details are removed from any records - please tick the box to confirm.

By signing below I agree to the statement relating to my personal data.

Signature: _____

Please send the completed form to:
The Committee, CDH UK,
C/O The Denes, Lynn Road Tilney All Saints,
Kings Lynn, Norfolk PE34 4RT
Email: committee@cdhuk.org.uk

cdh UK The Congenital Diaphragmatic Hernia Charity