SENIF Panel Review Form - CONFIDENTIAL

For FEEE children who have previously been approved at the SENIF Panel

Areas in **Purple** to be completed by Provider and returned to [EYSEND.Panel@walthamforest.gov.uk](mailto:EYSEND.Panel@walthamforest.gov.uk)

**Section 1**

Referral **MUST** be made by the childcare provider where the child is attending childcare provision

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| **1A Referrer Details: if child is currently attending a childcare provision** | |
| **Name of childcare provider** |  |
| **Childcare Providers OFSTED registration number** |  |
| **Contact name and job title**  SENCO or Child’s Key Worker |  |
| **Telephone number** |  |
| **Email address** |  |

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| **1B Referrer details: if child is not currently attending a childcare provision** | |
| **Referrers name and job role**  Child’s Lead Professional on LBWF framework system |  |
| **Address and postcode** |  |
| **Telephone number** |  |
| **Email address** |  |

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| **1C Single or Group Application** | | |
| **Type of application** | Single Child | Group of Children |
| **If Group Application, specify application number** If 4 children - Application numbers would be 1 of 4, 2 of 4, 3 of 4 and 4 of 4. | Application No \_ **of** \_ | |

**Section 2**

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| **2A Child’s Details** | | | |
| **Child’s Full Name** |  | **Gender** |  |
| **Date of birth** |  | **Age in months** |  |

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| **2B Child at Setting** | | | | | | | | | | | | | |
| **Date Child started at setting** | |  | | | | | | | | | | | |
| **Attendance hours** | | **Mon** | | | **Tues** | **Wed** | | | **Thur** | **Fri** | | | **Weekly Total** |
|  | | |  |  | | |  |  | | |  |
| **FEEE Eligibility** | 2YO FEEE 15hrs | | | 3YO FEEE 15hrs | | | | 3YO FEEE 30hrs | | | | Eligibility code: | |
| **Funding Eligibility** | | | **EYPP**  Yes  No | | | | **DLA**  Yes  No | | | | **DAF**  Yes  No | | |

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| **2C SEND Status** | | | |
| **Does the child have a SEND diagnosis?**  Supporting documentation must be sent as evidence**.** | Yes | No | SEND Diagnosis: |
| **Has the child been referred to any specialist service?**  E.g. Health, SACC | Yes | No | Name of specialist service:  Date of referral: |
| **Has EHCP referral been made?** | Yes | No | Date of application: |

**Section 3**

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| **3A Current Attainment and Summary of Concerns** |
| In the three areas below, indicate child’s attainment in line with [Development Matters](https://www.foundationyears.org.uk/files/2012/03/Development-Matters-FINAL-PRINT-AMENDED.pdf) indicators  Mark **X** in the relevant box to show child’s attainment when SENIF funding was **FIRST** applied for.  Mark **O** in the relevant box to show child’s **CURRENT** attainment at setting. |

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| **Communication and Language** (D= Developing, W = Working within S= Secure) | | | | | | | | | | | | | | | | | |
| **0-11 months** | | | **8-20 months** | | | **16-26 months** | | | **22-36 months** | | | **30-50 months** | | | **40-60 months** | | |
| **D** | **W** | **S** | **D** | **W** | **S** | **D** | **W** | **S** | **D** | **W** | **S** | **D** | **W** | **S** | **D** | **W** | **S** |
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| **Provide summary of the child’s development while being at the setting:** | | | | | | | | | **Provide summary of any ongoing concerns regarding the child’s development:** | | | | | | | | |
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| **Physical Development** (D= Developing, W = Working within S= Secure) | | | | | | | | | | | | | | | | | |
| **0-11 months** | | | **8-20 months** | | | **16-26 months** | | | **22-36 months** | | | **30-50 months** | | | **40-60 months** | | |
| **D** | **W** | **S** | **D** | **W** | **S** | **D** | **W** | **S** | **D** | **W** | **S** | **D** | **W** | **S** | **D** | **W** | **S** |
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| **Provide summary of the child’s development while being at the setting:** | | | | | | | | | **Provide summary of any ongoing concerns regarding the child’s development:** | | | | | | | | |
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| **Personal, Social and Emotional Development** (D= Developing, W = Working within S= Secure) | | | | | | | | | | | | | | | | | |
| **0-11 months** | | | **8-20 months** | | | **16-26 months** | | | **22-36 months** | | | **30-50 months** | | | **40-60 months** | | |
| **D** | **W** | **S** | **D** | **W** | **S** | **D** | **W** | **S** | **D** | **W** | **S** | **D** | **W** | **S** | **D** | **W** | **S** |
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| **Provide summary of the child’s development while being at the setting:** | | | | | | | | | **Provide summary of any ongoing concerns regarding the child’s development:** | | | | | | | | |
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| **3B Services and Activities** | | | | | | | |
| **Provide details of the services/activities that are currently being accessed by the family to support the child’s development**  (e.g. health, children & family centres, early help, private and voluntary sector providers and the parents own input) | | | | | | | |
| **Service description**  (name) | **Service Provider** | **Start date** (approx.) | **End date**  (if applicable) | **Frequency**  **e.g. once a week** | **Duration e.g. 2 hours** | **Cost per session** | **Funded by**  e.g. Parent, free |
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| **Provide details of the services/activities that are currently being accessed/provided by the setting to support child’s development**  (e.g. EPs, SaLT, All Talk, Staff training, additional resources) | | | | | | | |
| **A. Early Years funding formula base rate** | **£4.85 per hour** | **B. Additional hourly supplement for deprivation** | | **£ per hour** | **Total Early Years funding formula hourly rate (A+B)** | | **£** |
| **Service description**  (name) | **Service Provider**  (setting name or another professional) | **Start date** (approx.) | **End date**  (if applicable) | **Frequency**  e.g. once a week | **Duration** e.g. 2 hours | **Cost per session** | **Funded by**  e.g. Deprivation supplement, SENIF Panel |
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**Section 4**

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| **4A Current Approved SENIF Funding** | | | | | | | |
| **Top Up Rate Per Hour** | |  | | **Top Up Rate Per Week** | |  | |
| **No. of hours topped up** | |  | | **Ratio** | |  | |
| **Funding Start Date** |  | | **Funding Review Date** |  | **Funding End Date** | |  |

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| **4B Review Request for Additional Funding**  Due to reduced adult: child ratio to above EYFS statutory requirements. ***There must be evidence for reduced ratios in professional reports and this must be shown in the costed SEND plan to support application request. If there is not a professional report, an EP report must be applied for first from the SENIF Panel.*** | |
| **Proposed start date for reduced ratios**  No retrospective payments will be made; start date should be set for the date of the panel or after. |  |

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| **2 year old children** | |  | **3 year old children** | |  | **Details of other children that will form part of the reduced ratio group** | | |
| **Ratio** | **Amount of hours required at this ratio per week** |  | **Ratio** | **Amount of hours required at this ratio per week** |  | **Child’s Initials** | **Childs D.O.B.** | **Application form completed for ALL children who form part of this reduced ratio group. See section 1C.** |
| 1:1  \*see below |  |  | 1:1  \*see below |  |  |  |  | Yes |
| 1:2 |  |  | 1:2 |  |  |  |  | Yes |
| 1:3 |  |  | 1:3 |  |  |  |  | Yes |
| \*1:1 ratio will only be approved in exceptional circumstances. |  |  | 1:4 |  |  |  |  | Yes |
|  |  |  | 1:5 |  |  |  |  | Yes |
|  |  |  | 1:6 |  |  |  |  | Yes |

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| **Rationale**  What will the expected additional benefits/outcomes for the child from being part of a reduced adult: child ratio be? |
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**Section 5**

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| **5A Compulsory Reports** | | |
| **Name of Report** | **Has this report been sent with the application form?** | |
| Updated Costed SEND PLAN including outcomes | Yes | No |
| Professionals Report with evidence for reduced ratios | Yes | No |
| **5B Additional Reports** | | |
| **Name of Report**  Completed during last 3 months. Where reports are addressed to the parent/carer you must obtain consent to share these with the panel as part of the application. | **Has this report been sent with the application form?** | |
| Educational Psychology Report | Yes | No |
| Speech and Language Therapy Report | Yes | No |
| Medical Report | Yes | No |
| Early Years Home Visitor Support Plan | Yes | No |
| Baseline Assessment of Child at setting | Yes | No |
| Settings most recent assessment of child | Yes | No |
| Other Professional Reports/medical reviews  Please specify: | Yes | No |

**Section 6**

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| **6A Agreement Signatures** | | | |
| **Referrer** | | | |
| **Signed:** |  | | |
| **Name *(please print):*** |  | **Date** |  |
| **Parent/Carer**  By signing this document, I consent to:   * the information contained in this report and the attached reports to be shared with the SENIF Panel in order to apply for additional funding to support my child. * sharing my child’s information with relevant education and health services professionals for the purpose of obtaining a full package of advice and services that my child might need. | | | |
| **Signed:** |  | | |
| **Name *(please print):*** |  | **Date** |  |
| **Parent/Carer Email** |  | **Parent/Carer Telephone** |  |