We are no longer accepting retrospective claims for the period prior to 1st April 2011.

For all claims during the period 1st April 2011 to 31st March 2012 applications must be in 2 weeks prior to 31st March 2013 for submission.

Care Claim Support
reclaiming care home and nursing home fees

Dear Sir/Madam,

Our service is solely concerned with obtaining NHS Continuing Health Care funding as well as recovering money that you may have wrongly paid towards the cost of long term care from the relevant NHS Primary Care Trust (PCT).

To commence this process we require the following:

1. A **Completed Questionnaire**. It is important that you fill this in to the best of your ability so that our assessors have the correct information. Please complete the questionnaire and return it to the address provided on the last page.

2. A **Signed Letter of Authority** from you in order for us to apply for the Claimant's relevant medical records if we feel the claim has merit. Please complete and sign the document titled "AUTHORITY TO ACT & CONSENT FOR RELEASE OF MEDICAL RECORDS" and return with the completed Questionnaire.

3. You **must** be acting as Power of Attorney or Deputy Order (**if the Claimant is alive**) or, Executor under a will or Administrator of an estate by Grant of Probate or Letters of Administration (**if the Claimant is deceased**), as we will also need to see documents in support of that role before proceeding. *(Note: A Power of Attorney is not valid for this process if the Claimant is deceased)*

Once we have received these documents our specialists will be able to understand fully the strength of the case. If your case has merit we will enter into an agreement with you under which there will be no charge for our work if your claim is unsuccessful. If your claim succeeds, however, and you recover money from the PCT, we will charge you a fee calculated at 25% of the total amount recovered. Our fee is subject to VAT at the standard rate.

How long your case may take to resolve depends on how quickly we are able to access the medical records and how quickly the PCT responds to the submissions we will make on your behalf.

Please note that our service is only available to Claimants in England and Wales.

We look forward to hearing from you.

Yours sincerely,

Charles Bailly
Care Team Manager
Augusta Assist Limited

We are no longer accepting retrospective claims for the period prior to 1st April 2011.

For all claims during the period 1st April 2011 to 31st March 2012 applications must be in 2 weeks prior to 31st March 2013 for submission.

Care Claim Support
reclaiming care home and nursing home fees

NHS Continuing Healthcare Questionnaire

Why do I need to complete this form?

This form needs to be completed so that we can assess the Claimant's potential claim for NHS Continuing Care funding.

Who should complete this form?

This form is to be completed by or on behalf of the person wishing to make a claim for recovery of care home fees. It is helpful if the person receiving care helps to complete the form although this is not necessary. If the form is being completed on behalf of a relative receiving care, it should be completed by the family member(s) who knows most about the relative's care. All answers are to be given to the best of your belief and will be kept strictly confidential.

What if I don't know the answer to all the questions?

Please answer all of the questions to the best of your ability and knowledge, but don't worry if you can't. It is important that you try to answer all questions accurately and include additional information where possible to give us the best opportunity to properly assess your claim.

What will this cost?

Upon receipt of the completed form, we will carry out a free and confidential assessment of your potential claim and will advise you of the merits of the potential claim in writing. There is no obligation on you to proceed. If, following our assessment of your potential claim, you do decide to instruct us to act on the Claimant's behalf, we will work on a ***No Win, No Fee*** *basis charging a fee of 25% Plus VAT of the total amount recovered. If we do not recover any money then you will pay nothing.*

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Personal Details of Person Receiving Care

Name: .....

Title (Mr/Mrs/Ms/Miss): .....

Home address (immediately prior to admission to care home): ……
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Date of birth: .....

Is the Claimant alive or deceased?: ..... Date of Death: ……..

Name and address of General Practitioner: ……
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Name of address of Social Worker/Care Co-ordinator: ……
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Diagnosed Medical Conditions/Illnesses: ……
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If you are aware of the Claimant being attended by any specialist health professionals (e.g. district nurses) please provide further details: ……
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Hospitals attended and any operations since being admitted into care: ……
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Care Home Details

Name and address of current Care Home (including date of admission): …….
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Please provide details of residency in any previous Care Home/s (including dates): ……..
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Please tick which of the following most accurately describes the place where the Claimant receives care:

- ☐ The Claimant's own home;
- ☐ Residential Home;
- ☐ Nursing Home;
- ☐ Elderly Mentally Infirmed Residential Home; or
- ☐ Elderly Mentally Infirmed Nursing Home.

It is important that you answer this question – if you are unsure of the answer, please telephone the place where the Claimant receives care and they will confirm which of the above applies. Alternatively, please let us know and we will be happy to find out on your behalf.

Please confirm the amount of care home fees that have been paid to date. Please provide an estimate if this figure is not known: ……
……

Please confirm the current amount being paid per week/month for care: ……
……

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Questions

Although some of these questions may be difficult for you to answer, please enter as much detail as possible. The information you provide helps us to ascertain your eligibility for NHS Continuing Healthcare Funding. If the Claimant is DECEASED please answer the questions relating to their needs prior to the claimants death.

Q1. Behaviour

Please tick which of the following statements best describes the Claimant (tick only one box):

- ☐ Cooperates with staff for all of their care and shows no signs of challenging behaviour.
- ☐ Displays some incidents of 'challenging' behaviour (verbal) which does not pose a risk to self or others and cooperates with all their care.
- ☐ Displays 'challenging' behaviour (verbal or physical) that follows a predictable pattern and does not pose a risk to self or others. They nearly always cooperate with staff when providing care.
- ☐ Displays challenging behaviour (verbal or physical) that poses a predictable risk to self or others. Staff are normally able to manage the behaviour with reassurance/distraction/removal and this usually minimises but does not always eliminate the risks.
- ☐ Displays challenging behaviour of a severity and/or frequency that it poses a significant risk to self or others. The behaviour requires a prompt and skilled response that is beyond planned intervention e.g. physical restraint, separation, removal, regular staff observations.
- ☐ Displays challenging behaviour of a severity and/or frequency and/or unpredictability that it presents a serious risk to self or others. Requires staff monitoring at all times for safe care.

Please tell us in your own words about the challenging behaviour the claimant displays. Include whether it is verbal and/or physical, how often it occurs, how predictable/unpredictable it is and how care staff manage it: ……..
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Q2. Cognition

Please tick which of the following statements best describes the Claimant (tick only one box):

- ☐ Does not have any cognitive impairment, confusion or disorientation.
- ☐ Has mild cognitive impairment which requires some supervision and prompting with daily living or making choices. They may have some difficulties with memory, but they are aware of risks.
- ☐ Has cognitive impairment that requires prompting and supervision with basic care and daily living. They are able to make choices about their care needs. However, they are unable to make some decisions which consequently puts them at risk of harm, neglect or health deterioration.

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- Disorientated to time and place. They are only aware of basic needs and risks. They are unable to make the majority of decisions which puts them at high risk of harm, neglect or health deterioration.
- Severely disorientated to time, place and person. Unable to assess even basic risks without supervision or assistance. Dependent on others to anticipate even basic needs.

Please tell us in your own words about the cognitive impairment the claimant has. How confused and disorientated they are, whether they can tell staff what they need and any memory issues: ……
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Q3. Psychological and Emotional

Please tick which of the following statements best describes the Claimant (tick only one box):

- Has no psychological or emotional needs.
- Shows symptoms of distress, anxiety or hallucinations which respond to reassurances.
- Shows symptoms of distress, anxiety or hallucinations which do not readily respond to reassurances.
- Shows symptoms of distress, anxiety or hallucinations which do not respond to reassurances and are having an impact on their health and wellbeing.

Please tell us in your own words about how the claimant is affected psychologically or emotionally. Tell us if they have a diagnosis of mental health, when and how often they are distressed or anxious, if they hallucinate, if they are withdrawn, how it affects them and how this is managed: ……..
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Q4. Communication

Please tick which of the following statements best describes the claimant (tick only one box):

- ☐ No communication issues, able to reliably communicate.
- ☐ Needs some assistance to communicate their needs. This might include touch, visual clues or attentive listening.
- ☐ Communication about their needs is difficult to understand or interpret. Unable to reliably communicate their needs, but staff may be able to anticipate their needs through non-verbal signs (i.e. facial expressions) due to familiarity with client.
- ☐ Unable to reliably communicate their needs at any time or in any way. Most of the needs have to be anticipated because of their inability to communicate.

Please tell us in your own words about how the claimant communicates with people and any difficulties they have: ……
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Q5. Mobility

Please tick all of the following statements that apply to Claimant:

- ☐ Independently mobile.
- ☐ Able to weight bear but needs some assistance.
- ☐ Not able to consistently weight bear.
- ☐ Unable to weight bear, but able to assist with transfers.
- ☐ Unable to weight bear or assist with transfers.
- ☐ Unsteady and at high risk of falls.
- ☐ Involuntary spasms or contractures that place themselves or staff at risk.
- ☐ Completely immobile and there is a high risk of serious physical harm with transfers and positioning is critical (i.e. to ensure airway is open).

Please tell us in your own words about how the claimant's mobility issues and the problems they experience. Include if they are at risk of falls (how often), how many staff are required to transfer and any physical conditions that make these difficult: ……
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Q6. Eating and Drinking

Please tick all of the following statements that apply to Claimant:

- ☐ No issues with eating and drinking.
- ☐ Needs supervision, prompting or feeding and/or a special diet.
- ☐ Needs feeding and takes a long time (half an hour or more).
- ☐ Unable to take food and drink by mouth and nutrition provided by artificial means (i.e. a non-problematic PEG).
- ☐ Unable to take food and drink by mouth and problems related to a feeding device (i.e. problematic PEG).
- ☐ Significant weight loss or gain.
- ☐ Risk of choking or aspiration.
- ☐ Difficulty with swallowing.
- ☐ Eating Disorder.
- ☐ Intravenous Fluids.
- ☐ Unable to take food or drink by mouth, intervention impossible or inappropriate.

Please tell us in your own words about any complications involved with the Claimant's eating or drinking. Include equipment, cooperation, health intervention (i.e. speech and language assessments): ……..
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Q7. Continence

Please tick all of the following statements that apply to Claimant:

- ☐ Not incontinent of urine and faeces.
- ☐ Incontinent of urine only.
- ☐ Incontinent of urine and faeces.
- ☐ Continence managed by regular toileting.
- ☐ Continence managed by pads.
- ☐ A stable stoma.
- ☐ Uses a catheter.
- ☐ Suffers with constipation.
- ☐ Suffers with UTIs (Urinary Tract Infections).
- ☐ Continence care is problematic and requires skilled interventions (i.e. enemas, manual evacuations).

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Please tell us in your own words about the Claimant's continence care. Please tell us about how this is managed and any complications they might have: ..……..
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Q8. Skin

Please tick all of the following statements that apply to Claimant:

- ☐ No issues with pressure sores or skin condition.
- ☐ Risk of skin breakdown requiring daily treatment.
- ☐ Risk of skin breakdown that requires regular turning or repositioning.
- ☐ Open Pressure sores or a skin condition that responds well to treatment.
- ☐ Open pressure sores or a skin condition that is not responding well to treatment.
- ☐ Specialist dressing regime that is responding to treatment.
- ☐ Specialist dressing regime that is not responding to treatment.
- ☐ Open wound or pressure sore extending to bone, tendon or muscle.
- ☐ Multiple wounds that are not responding to treatment.

Please tell us in your own words about the Claimant's skin condition. Please tell us about the condition, how often it occurred, how this is managed and any complications they might have: ……..
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Q9. Breathing

Please tick all of the following statements that apply to Claimant:

- ☐ Normal breathing, no issues.
- ☐ Shortness of breath or uses inhalers or nebulisers with no impact on daily living.
- ☐ Shortness of breath or uses inhalers or nebulisers which limit some aspects of daily living.
- ☐ Shortness of breath or uses inhalers or nebulisers which does not respond to treatment and limits all aspects of daily living

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Does the Claimant require any of the following?:

- ☐ Low level oxygen therapy.
- ☐ Air ventilation via a facial mask.
- ☐ CPAP.
- ☐ Other therapeutic appliance to maintain airflow.
- ☐ A tracheotomy.
- ☐ Difficulty in breathing which requires suction to maintain.
- ☐ Severe breathing difficulties at rest despite medical therapies.
- ☐ Unable to breathe independently and requires medical ventilation.

Please tell us in your own words about the Claimant's breathing. Please tell us about the condition, how this is managed and any complications they might have: ……..…….
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Q10. Drug Therapies and Medication

Please tick all of the following statements that apply to Claimant:

- ☐ Symptoms (and/or side effects) managed effectively by medication.
- ☐ Requires supervision and/or prompting with medication.
- ☐ Compliant with medication regime.
- ☐ Not compliant with medication regime.
- ☐ Requires medication to be administered (e.g. insulin).
- ☐ Requires liquid medication.
- ☐ Medication requires monitoring by a trained nurse or carer because of risks involved, but is not problematic.
- ☐ Medication requires monitoring by a trained nurse or carer because of risks involved, but is still problematic.
- ☐ Medication requires daily monitoring by a registered nurse to ensure effective symptom and pain management with a rapidly changing and/or deteriorating condition (i.e. morphine).
- ☐ Mild pain that is predictable.
- ☐ Moderate pain that is predictable.
- ☐ Moderate pain that has an impact on care provided.
- ☐ Severe recurrent or constant pain which is not responding to treatment.
- ☐ Unremitting pain which is not controlled effectively.

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Please tell us in your own words about the Claimant's medication. Please tell us about the condition, how this is managed and any complications they might have: ……..……..
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Q11. Altered States of Consciousness

Please tick which of the following statements best describes the Claimant (tick only one box):

- ☐ Does not suffer with seizures, TIAs, strokes, dizziness or feinting attacks.
- ☐ History of epilepsy, seizures, TIAs, strokes, dizziness or feinting attacks and there is a low risk of harm.
- ☐ Occasional (monthly) episodes of epilepsy, seizures, TIAs, strokes, dizziness or feinting attacks that require the supervision of a carer to minimise harm.
- ☐ Occasional (monthly) episodes of epilepsy, seizures, TIAs, strokes, dizziness or feinting attacks that require skilled intervention to minimise harm (i.e. rectal diazepam).
- ☐ Frequent (weekly) episodes of epilepsy, seizures, TIAs, strokes, dizziness or feinting attacks that require the supervision of a carer to minimise harm.
- ☐ Episodes of epilepsy, seizures, TIAs, strokes, dizziness or feinting attacks that occur most days and result in a severe risk of harm.
- ☐ In a coma.

Please tell us in your own words about the Claimant's altered states of consciousness. Please tell us about the condition, how this is managed and any complications they might have: ……..…...
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Q12. Other significant care needs

Please provide details of any care needs the Claimant has which have not been covered in the previous 11 questions. Please also feel free to include any additional information which you feel might assist us to assess your potential claim: ……
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Additional Information

If you are completing this form on behalf of the Claimant, please provide the following information about you:

Name: .....

Title (Mr/Mrs/Ms/Miss): .....

Home address: ……..…….
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.....

Home Telephone: ……..……..

Mobile Telephone: ……..…….

Email address: ……..……

Relationship with the Claimant: ……..……

How did you find out about us?: …….....

If the Claimant has the capacity to manage their own affairs but wants you to act on their behalf, do you have any of the following?

- ☐ Enduring Power of Attorney.
- ☐ Lasting Power of Attorney for Property and Affairs.
- ☐ Lasting Power of Attorney for Health and Welfare.

If the Claimant does not have capacity to manage their own affairs, do you have any of the following?

- ☐ Registered Enduring Power of Attorney.
- ☐ Registered Lasting Power of Attorney.
- ☐ Deputy Order.

If the Claimant is now deceased, do you have any of the following?

- ☐ Grant of Probate.
- ☐ Grant of Letters of Administration.
- ☐ Executor of a Will.

Has the Claimant previously contacted the local health authority (i.e. local Primary Care Trust and/or Strategic Health Authority in England or Local Health Board, NHS Trusts and/or new Health Board in Wales) regarding the possibility of NHS funding of the care? **If yes**, please answer the following questions:

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a) When did you first contact the health authority? ……..
……
……

b) Please provide details of any response received to your request. Please also enclose any copy documents (e.g. letters from the local health authority) when returning this form: ……
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Thank you for completing this questionnaire. Please now email this to info@careclaimsupport.co.uk or post it to:

Augusta Assist Ltd
Suite 4
The Granary
1 Waverley Lane
Farnham
Surrey
GU9 8BB

If you do not wish to receive updates and information on our other services as well as from related third party services please tick this box □

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AUTHORITY TO ACT
&
CONSENT FOR RELEASE OF MEDICAL RECORDS
Application for Access to Health Records
(Data Protection Act 1998)

Please return the completed form to:

Augusta Assist Ltd
Suite 4
The Granary
1 Waverley Lane
Farnham
Surrey
GU9 8BB

NAME of Claimant: .....
(The person receiving care, even if deceased)

ADDRESS of Claimant: .....
(The care home currently in, if deceased the home prior to death)
.....

.....

Date of Birth of Claimant: .....

I authorise Augusta Assist Limited to act on behalf of the Claimant (above) in all matters relating to Continuing Healthcare funding.

I consent to the disclosure of my medical notes and other records (in whatever form), including assessments, treatments, records, checklists, deliberations of panels and multidisciplinary teams, in each case both past and present, to Augusta Assist Limited. The purpose of the disclosure is to establish any entitlement I may have to NHS or other public funding for my care including any entitlement to a retrospective claim. I confirm that, in respect of this disclosure, I have waived all rights of confidentiality.

Augusta Assist Limited may disclose any medical notes, records or details to any medical or other expert (in connection with my proposed claim) or to any medical practitioner, hospital trust or care home, in each case as it considers necessary.

I consent to the preparation of medical reports concerning me, prepared by or on behalf of Augusta Assist Limited.

Signed: ..... **on behalf of Claimant**

Name of signatory: .....
(The person acting on behalf of the person receiving care)

Acting under authority of ..... **(Please enclose copy)**
(Type of authority you are acting under)

If alive: Power of Attorney, Deputy Order, Marriage Certificate (if acting on behalf of spouse)
If deceased: Grant of Probate, Letters of Administration, Last Will, Marriage Certificate (if acting on behalf of spouse)

Dated: .....