Kent County Council

You **must** read this carefully before proceeding with this referral.

Introduction

The Benefits Team support adult clients with an ongoing involvement within the Adult Social Care Directorate.

The client must be receiving a chargeable service (a service which requires a financial assessment) or be a client of a joint KCC / Mental Health Team. The client must have a current MOSAIC/LPS record reflecting the team/ worker involvement.

Referrals can only be accepted where there is a complex benefit issue such as:

- challenging incorrect benefit decisions via the appeal system
- supporting requests for an increase in rates of an existing disability benefit due to a change in needs
- advising on complex issues affecting entitlement such as immigration issues

We cannot accept referrals to assist service users solely with making a new benefit claim.

If in doubt please seek advice from the Benefits Team by emailing benefitsteam@kent.gov.uk

If a referral is not appropriate we will provide advice to the worker regarding the issue and where possible suggest alternative sources of support.

Criteria for Benefit Team Involvement

Referrals will not be accepted with insufficient information

The following information **MUST** be provided with this referral form:

- benefit letters regarding the benefit issue
- signed authority from client or financial agent (print the form at end of this document and submit a completed scanned copy with this referral)

Is the client under the KCC / Mental Health Team? Yes No

By ticking this box you are agreeing that **YOU** have checked that this client meets **ALL** the above criteria.

Failure to provide the information needed will result in this referral being declined

If any of the answers are "Not Applicable or Unknown" please state "NA" or "NK"

Service User Details

Name:

Date of Birth:

Title:

National Insurance Number:

MOSAIC/ LPS ID:

Social Care Team:

Case Manager / Care Co-ordinator:

Carer/Support Worker/Family Support:

Address:

Please specify:

Contact telephone number/s:

Email address:

Nationality:

If non UK/EEA please state immigration status:

Reason for referral:

Diagnosis of health condition or disability:

Special factors such as potential risks; joint working required; interpreter required; contact via third party:

Is the client aware of and in agreement for the referral to be made? ☐ Yes ☐ No

Partner name:

Children in household (under 20) and ages:

Non-dependants (other people living in the household):

Financial Details at point of referral:

Capital details:

Income details:

Appointee/Receiver/Deputy/Power of Attorney (if applicable)

Does this client have an appointee/receiver/deputy/power of attorney? ☐Yes ☐No

Referrer Details

Name: | Job Title:
Email Address: | Team:
Office Address:
Telephone: | Referral Date:

The section below will be filled in by the Client Financial Services Team

Allocated Officer Name: | Locality/District:
Source Team:
Client Group:
Primary Reason for Referral:
Chargeable Provision: ☐Yes ☐No
Financial Assessment: ☐Yes ☐No

Office Use Only: Date:

Date Referral input to spreadsheet:

Date Referral input to MOSAIC/LPS:

Failure to submit a completed Benefits Team referral form and all relevant evidence / documentation required will result in this referral being declined

Please email the completed form and any accompanying paperwork to benefitsteam@kent.gov.uk

Kent County Council

NOTICE OF AUTHORITY TO ACT

This is to authorise ...., Benefit Adviser, to act on my behalf.

OFFICE ADDRESS: ....

....

....

....

....

TELEPHONE NUMBER:

Please give the above representative any details in relation to my claim/dispute for

....

for the period of the duration of this enquiry.

Could you also keep my representative informed of the progress of the claim and any decisions made?

SIGNED: ....

DATED: ....

NAME: ....

NI No: ....

DATE OF BIRTH: ....

ADDRESS: ....

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