

APPLICATION FOR SHORT BREAK INCLUSION FUNDING 2025-26

1. Service details

Name of Service	
Address of Service	
Name of Leader/Manager	
Correspondence Address if different from above	
Day Time Telephone number/s	
Email Address	
Date of Application	

2. Child details

Name	
Age	
Date of Birth	
Address	

3. Sessions requested

February Half Term Holiday	<input type="checkbox"/>	Spring Term Before or After School Club	<input type="checkbox"/>
Easter Holiday	<input type="checkbox"/>	Summer Term Before or After School Club	<input type="checkbox"/>
May Half Term Holiday	<input type="checkbox"/>	Autumn Term Before or After School Club	<input type="checkbox"/>
Summer Holiday	<input type="checkbox"/>	Early Years Setting Term time	<input type="checkbox"/>
October Half Term Holiday	<input type="checkbox"/>	Early Years Setting School Holidays	<input type="checkbox"/>
Christmas Holiday	<input type="checkbox"/>		

3a. Times of Sessions Before and After School Club

Day	Time: Am		Time: Pm		Dates of sessions	
	From	Until	From	Until	Start Date	End Date
Monday						
Tuesday						
Wednesday						
Thursday						
Friday						

3b. Times of Sessions School Holiday Clubs/Playschemes

Day	Time		Dates of sessions	
	From	Until	Start Date	End date
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				

3c Times of sessions Early Years Settings

Day	Time		Dates of sessions	
	From	Until	Start Date	End date
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				

4. Amount requested towards staffing costs.

A	B	C	(A x B x C)
Hourly rate	Hours per week	Number of Weeks	Total Cost £
£7.50			

5. Amount requested for resources please attach quote for each item requested. Proof of purchase will be required.

Item to be purchased	Amount Requested

- 6. Essential Training costs for Health Care tasks** e.g. Emergency epilepsy medication, PEG feeding, Oxygen Administration etc. Training is for a maximum of two staff members. Proof of attendance will be required.

Training Requested	Number of staff	Amount requested

- 7. How will the Short Break Inclusion Funding be used and how will this meet the needs of the child or young person?**

Please indicate how the funding will be used to support the child's inclusion e.g. towards additional staffing costs, training, a resource, or something else. Please give detail about how this will support the child and what this will enable to child to do which otherwise would not be possible.

8. Signature of Provider

Signature of person completing the application	
Designation	
Date	

9. Signatures Parents/Young People

Are Autism Outreach involved with the child? If yes, then they may be informed that the child is attending the provision to promote partnership working if required	Yes <input type="checkbox"/> No <input type="checkbox"/>
Signature of Parent/Carer for consent to this.	
Date of signature	
I confirm that I am the parent/carers of the child who this Inclusion Funding application is being submitted for, and that I have chosen this service and have checked that it is a safe and suitable provision which can meet the needs of my child.	
Signature of Parent/Carer	
Date of signature	
Signature of young person aged 16+ (If signature obtained, please submit relevant completed Mental Capacity Assessment for this if applicable.)	
Date of signature	

10. Submit

Please send to: Childcare@leics.gov.uk via Egress secure email – Please also contact the service using this email if you require assistance setting up an Egress account.

Before submitting, please ensure that all parts of the form are completed and any quotes are attached or unfortunately the application will not be processed.