NHS SCOTLAND

Young Patients Family Fund (YPFF) claim form (YPFF(1)): travel, subsistence and/or accommodation costs for families with babies, children and young people under the age of 18 in inpatient care

YPFF is a Scottish Government fund designed to support parents/primary carers and any accompanying siblings under the age of 18 with the costs associated with visiting a young inpatient* aged under 18 in hospital**. Claimants must be ordinarily resident in Scotland.

* Young inpatient - a baby, child or young person up to age 18 who is admitted to an available staffed bed in a hospital (either electively or as an emergency) and either: remain overnight whatever the original intention; or are expected to remain overnight but are discharged earlier.

** Also applies to NHS run short break facilities and- Children's Hospices Across Scotland (CHAS) facilities.
Any reference to 'hospital' in this document should also be taken to include NHS run short break facility and CHAS facilities.

What Expenses Can be Claimed
(the claim must be as a direct result of visiting a young inpatient in Scotland.)

- **Transport** - Public transport costs should be reimbursed in full for up to one return journey per day for each claimant on production of receipts. Only standard class travel can be reclaimed. Travel by taxi will only be considered in certain circumstances, e.g. no public transport availability or subject to a visitor's medical condition. Taxi travel must be approved by clinical staff prior to journey. Contributions towards the cost of fuel will be reimbursed at the prevailing mileage rate*** per mile for up to one return car journey per day for each claimant, when they are travelling to the hospital separately on the same day. If all claimants travel together, the cost of only one return journey should be reclaimed.

*** The rate of reimbursement is based on the HMRC Fuel Advisory Rate. This can be found at:
https://www.gov.uk/government/publications/advisory-fuel-rates.

- **Meals and subsistence** - A contribution of **up to £8.50** per eligible visitor per day for food and non-alcoholic beverages can be claimed. Meals and subsistence may be purchased outside of hospital grounds.
- **Parking** - Car parking costs can be reclaimed in full on the submission of receipts.
- **Accommodation** – In the exceptional circumstances where hospital accommodation is not available, a contribution to reasonable overnight accommodation costs will be reimbursed.

MAKING A CLAIM

The YPFF(1) form is set out below, further forms may be available from hospital wards, clinics and cash offices or to download. The form should be completed, signed and certified as detailed on the form. This includes certification by a relevant medical professional caring for your baby, child or young person. Claims can be made individually or one individual can make a claim for all eligible visitors using a single form, e.g. a mother can submit a claim on behalf of herself, the father and sibling of a young inpatient.

Claims can be submitted incrementally during an on-going hospital stay (e.g. weekly) or in full for the entire stay, following discharge from the ward where the child or young person is receiving ongoing treatment.

Claims must be submitted within three months of the patient's discharge from hospital. Claims outside this time will not be considered for reimbursement except in exceptional circumstances.

On completion the forms must be handed into the cash office within the hospital of attendance for processing.

Claimants must read the full terms and conditions of the fund before making a claim.

The terms and conditions can be found at
https://www.mygov.scot/young-patients-family-fund-terms-conditions

YPFF (1) CLAIM FORM

SECTION 1: DECLARATION AND SIGNATURE BY (OR ON BEHALF OF) CLAIMANT

I certify that I have read and understand the Travel and Subsistence Rules and conditions under which I am claiming these expenses. I confirm that this claim complies with these rules and conditions. I certify that I am the parent/primary carer or sibling under 18 of a baby, child or young person who has received or is receiving inpatient care as outlined in this form and declare that the information I have given on this form is correct and complete and that I have not claimed elsewhere for the expenses detailed on this form.

I understand that if I knowingly provide false information this may result in legal action and I may be liable to prosecution and civil recovery proceedings. I consent to the disclosure of information from this form to and by NHS Scotland and Counter Fraud Services for the purposes of verification of this claim and the investigation, prevention, detection and prosecution of fraud.

I understand that if I am making a claim outside my NHS Board of residence, that this claim form may be shared with the cash office in my home Health Board.

Print Name:

Signature:

Relationship to Claimant if applicable

Date:

CLAIMS MUST BE SUBMITTED WITHIN 3 MONTHS OF DISCHARGE FROM HOSPITAL AND HANDED TO THE CASH OFFICE OF THE HOSPITAL ATTENDING.

SECTION 2: PATIENT DETAILS TO BE COMPLETED BY (OR ON BEHALF OF) CLAIMANT

Patient's Details (If baby is unnamed please write mother's surname)

Forename ______ Surname ______

Patient's age at admittance ______

Patient's DOB D D M M Y Y Y Y

Patient's CHI number ☐☐☐☐☐☐☐☐☐☐

Hospital/Facility attended ______

Ward Number ______

Consultant's Name ______

Date of admission D D M M Y Y Y Y

Time of admission ______

Date of discharge (if applicable) D D M M Y Y Y Y

Time of discharge (if applicable) ______

Please tick here if your claim relates to the receipt of care in a Neonatal Unit ☐

Please tick here if your claim relates to receipt of care in any other ward ☐

Please tick here if your claim relates to receipt of care in a NHS run short break ☐

Please tick here if your claim relates to receipt of care in a CHAS facility ☐

SECTION 3: CLAIMANT'S DETAILS TO BE COMPLETED BY (OR ON BEHALF OF) CLAIMANT

Claimant's forename [ ] Surname [ ]

Claimant's address [ ]

Postcode [ ] Phone Number [ ]

Email address [ ]

Are you the Parent/Primary Carer of the young inpatient? [ ]

Are you an eligible sibling (must be under 18) of the young inpatient? [ ]

Name(s) of Parent(s)/Primary Carer(s) of the young inpatient who are benefiting from this claim [ ]

Names of any siblings (under 18 years old) of the young inpatient who are benefiting from this claim.

Using details from the questions above, please provide the **numbers** of persons who are associated with **this** claim.

Number of Parent(s)/Primary carer(s): [ ]

Number of Eligible Sibling(s): [ ]

Total Number [ ]

SECTION 4: PAYMENT DETAILS TO BE COMPLETED BY (OR ON BEHALF OF) CLAIMANT

BANK DETAILS (Only to be completed if you wish to be paid by Bank Transfer and the hospital has the facilities to process such a transfer.)

NAME OF ACCOUNT HOLDER(S): [ ]

BANK/BUILDING SOCIETY NAME: [ ]

BRANCH SORT CODE: [ ][ ] [ ][ ] [ ][ ]

BANK/BUILDING SOCIETY ACCOUNT NUMBER: [ ][ ][ ][ ][ ][ ][ ][ ]

SECTION 5: DETAILS OF THE CLAIM TO BE COMPLETED BY (OR ON BEHALF OF) CLAIMANT

Date	Expenses Type (e.g. car/ bus/meal	Eligible Visitor which the claim pertains to (parent, primary carer or sibling under 18 – claimants can list more than one eligible visitor per row where appropriate)	Details of expenses	Meal and subsistence (up to £8.50 per person per day)	Mileage	Amount Claimed
EXAMPLE: 01/04/2024	MOTOR MILEAGE	PARENT	RETURN CAR JOURNEY FROM HOME ADDRESS TO HOSPITAL	N/A	10 MILES claimed at the prevailing mileage rate****	Claimant should calculate this using HMRC mileage rate guidance.
01/04/2024	MEALS/ SUBSISTENCE	PARENT & 1 SIBLING	COST OF MEALS PURCHASED DURING HOSPITAL VISIT	2 x 5.70		11.40

**** The rate of reimbursement is based on the HMRC Fuel Advisory Rate. This can be found at: https://www.gov.uk/government/publications/advisory-fuel-rates.

SECTION 6: AUTHORISATION TO BE COMPLETED BY HOSPITAL STAFF

Hospital staff must cross out all unfilled sections of the claim form in Section 5 before signing this authorisation.

I confirm that the patient named above is/was an inpatient in this hospital on the dates stated in Section 2, and that the details of the claim in Section 5 are correct to the best of my knowledge.

Signature:

Print name:

Designation:

Date:

SECTION 7: FOR OFFICE USE ONLY

I have checked the details of this claim as listed above and hereby process payment of

£

Signature

Print name:

Designation:

Date:

Hospital Stamp