Young Patients Family Fund (YPFF) claim form (YPFF1): 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.

What Expenses Can be Claimed

- **Transport** - Public transport costs should be reimbursed in full for up to one return journey per day for each claimant and any accompanying sibling(s) up to the age of 18 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.
- **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 circumstance where hospital accommodation is not available, a contribution to reasonable overnight accommodation costs will be reimbursed.

*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.

Making a claim

The YPFF(1) form is attached, further forms may be available from hospital wards, clinics and cash offices or to download. The form should be completed by one claimant and 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 on-going 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 very exceptional circumstances.

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

Full terms and conditions of the fund can be found at **https://www.mygov.scot/young-patients-family-fund-terms-conditions**

YPFF (1) CLAIM FORM

SECTION 1: PERSONAL DETAILS: TO BE COMPLETED BY (OR ON BEHALF OF) CLAIMANT

PATIENT NAME (If baby is unnamed please write Baby's Surname)

PATIENT'S AGE AT ADMITTANCE:

PATIENT DATE OF BIRTH: D D M M Y Y Y Y

PLEASE TICK IF YOU ARE CLAIMING IN RESPECT OF VISITING A BABY RECEIVING CARE IN A NEONATAL UNIT ☐

CLAIMANT'S NAME:

CLAIMANT'S ADDRESS:

POST CODE: CONTACT PHONE NUMBER:

RELATIONSHIP TO PATIENT: parent/primary carer ☐ sibling(s) under 18 ☐ quantity ☐

(If making a claim for more than one eligible visitor please tick all that apply and detail the numbers of parents/primary carers and/or siblings making a claim)

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

NAME(S) OF ACCOUNT HOLDER(S):

BANK/BUILDING SOCIETY NAME:

BRANCH SORT CODE:

BANK/BUILDING SOCIETY ACCOUNT NUMBER:

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

HOSPITAL ATTENDED:

WARD NUMBER/NAME:

CONSULTANT NAME: (if applicable)

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)

SECTION 3: AUTHORISATION: TO BE COMPLETED BY HOSPITAL STAFF

I confirm that the patient named above is/was an inpatient in this hospital on the dates stated in Section 2:

Signature:

Print Name:

Designation:

Date: D D M M Y Y Y Y

Signature of authorised member of hospital staff:

SECTION 5: DETAILS OF 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 expense	Meal and subsistence (up to £8.50 per person per day)	Mileage	Amount Claimed
EXAMPLE: 01/01/18	CAR		RETURN CAR JOURNEY FROM HOME ADDRESS TO HOSPITAL		10 miles at 14p per mile	£1.40
01/01/18	MEAL	PARENTS/PRIMARY CARERS AND SIBLING(S) UNDER 18	COST OF MEALS PURCHASED DURING HOSPITAL VISIT.	3		£25.50
			TOTAL			

SECTION 5: 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.

Signature:

Date: D D M M Y Y Y Y

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

SECTION 6: FOR OFFICE USE ONLY

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

Signature:

Designation:

Date: D D M M Y Y Y Y

version 2

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