EHAP Registration No.

Early Help Assessment and Plan (EHAP) Form

This EHAP form replaces the Common Assessment Framework (CAF) form. The process for assessing the needs of a child/young person/family and creating an action plan to address those needs - remains the same.

Before initiating use of an EHAP

1 Ensure there are **NO immediate child protection concerns.**
If at any time you are concerned about the welfare or safety of a child/young person – call the Ealing Children's Integrated Response Service (ECIRS) to discuss your concerns and get advice. Appropriate action will then be taken **020 8825 8000** (24hrs).

2 Consider whether **a multi-agency approach is necessary** - or whether a single organisation/service can meet all the child/young person's needs.

3 You must contact the Family Information Service (FIS) to **find out if an EHAP is already in use** for the child/young person or a sibling. And to obtain the registration number and Lead Professional contact details (for an existing EHAP) or **register a new EHAP**. Call **020 8825 5588** (Mon-Fri, 9am-5pm).

EHAP Initiator comment

Use this space to explain why an EHAP is being initiated for this child/young person giving a brief overview of possible needs. Include an overview of the home situation and family structure.

EHAP Initiator's details

Date EHAP initiated: _____ Full name: _____

Role: _____ Organisation/service: _____

Tel: _____ Email: _____

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www.ealing.gov.uk

Identifying Details

EHAP No. _____

Child/young person's details

If unborn baby state name as 'unborn baby' and mother's full name e.g. 'unborn baby of Ann Smith'

First name: _____

Surname: _____

Previous name: _____

Date of birth or expected date of delivery: _____

Gender: ☐ Male ☐ Female ☐ Unknown

Address: _____

_____

_____ Postcode: _____

Tel: _____

Family's religion: _____

School (name and town): _____

_____

GP name: _____

GP address: _____

_____

_____ Postcode: _____

GP tel: _____

NHS no. (if known) _____

Parent/carer (1)

First name: _____

Surname: _____

Address: (if different from child/young person) _____

_____

_____ Postcode: _____

Tel: _____

Relationship to child/young person: _____

Parental responsibility: ☐ Yes ☐ No

Parent's first language: _____

Is an interpreter required for meetings? ☐ Yes ☐ No

Parent/carer (2)

First name: _____

Surname: _____

Address: (if different from parent/carer 1) _____

_____

_____ Postcode: _____

Tel: _____

Relationship to child/young person: _____

Parental responsibility: ☐ Yes ☐ No

Parent's first language: _____

Is an interpreter required for meetings? ☐ Yes ☐ No

Sibling's name	Gender	Date of birth	School

Additional needs/disability/SEN

Does the child/young person have additional needs, special educational needs or a disability?

☐ Yes ☐ No If yes, give details: _____

_____

_____

Does the child/young person have a statement of special educational needs? ☐ Yes ☐ No

Does anyone in the family have any accessibility requirements for meetings?

☐ Yes ☐ No If yes, give details: _____

_____

_____

_____

Is this child/young person a young carer?

☐ Yes ☐ No ☐ Uncertain

Ethnicity

EHAP No. _____

Asian or Asian British

- Indian ☐
- Pakistani ☐
- Bangladeshi ☐
- Any other Asian background* ☐

Black or Black British

- Caribbean ☐
- African ☐
- Any other Black background* ☐

Chinese or other ethnic group

- Chinese ☐
- Arab ☐
- Any other ethnic group* ☐
- Not given ☐

Mixed

- White & Black Caribbean ☐
- White & Black African ☐
- White & Asian ☐
- Any other mixed background* ☐

White

- White British ☐
- White Irish ☐
- Gypsy/Roma ☐
- Traveller of Irish heritage ☐
- Any other White background* ☐

*If other please specify:

_____

_____

_____

Services already working with this child/young person and their family

_____ _____

_____ _____

Consent for information storage and information sharing

I understand the information recorded on this form. I give consent to my information being shared with the services indicated with a tick ☑ below for the purpose of setting up the first Team Around the Family meeting to enable access to help and support from these services.

- ☐ Family Information Service (for support and/or to register this EHAP)
- ☐ Children's centres
- ☐ Childcare provider
- ☐ School
- ☐ Health
- ☐ Youth services
- ☐ Police
- ☐ ECIRS (Ealing Children's Integrated Response Service)
- ☐ ESCAN (Ealing Service for Children with Additional Needs)

Please be aware we will contact Social Services if at any time during the EHAP process the child/young person has been harmed or is at risk of harm or abuse.

Full name (BLOCK CAPITALS): _____

Signature: _____ **Date:** _____

I am ☐ the young person (aged 12-16), ☐ the parent of the child/young person, ☐ the carer of the child/young person.

Verbal consent to initiate an EHAP may be given by the young person (aged 12-16) and/or their parent/carer. However, written consent must then be obtained at the very first opportunity and BEFORE any information can be shared or stored electronically. For children under the age of 12, parental consent must be obtained before initiating an EHAP.

Verbal consent obtained from: _____ **Date:** _____

EHAP Initiator's full name: _____ **Signature:** _____

Early Help Assessment

EHAP No.

Date of first TAF: _____

Child/young person's full name: _____ Date of birth: _____

Lead Professional: _____

Role: _____ Organisation/service: _____

Tel: _____ Email: _____

Attendee (full name)	**Role**	**Organisation/service**	**Tel**

Development of unborn baby, child or young person:

Parents and carers:

Family and environment:

Is the child/young person involved in caring for a relative or sibling on a regular basis?

Analysis and summary of assessed needs:

Action Plan

EHAP No.

Needs and desired result (Number in order of priority)	**Planned actions** (Indicate name/service)	**Desired completion date**

Family or young person's comment on the action plan or anything else so far:

Consent for assessment, agreed actions and choice of Lead Professional

I understand and agree with the assessment and proposed action plan and choice of Lead Professional. I consent to my information being shared with the services identified in the action plan for the purpose of accessing these services.

Full name (BLOCK CAPITALS): _____

Signature: _____ Date: _____

I am ☐ the young person (aged 12-16) ☐ the parent of the child/young person ☐ the carer of the child/young person

Agreed date for next Team Around the Family meeting (review): _____

Lead Professional's full name: _____ Signature: _____

Lead Professional checklist

- ☑ Ensure the security of this form and its contents both paper and electronic.
- ☑ Notify the Family Information Service (FIS) of the first TAF meeting and planned review date, giving your contact details as the Lead Professional.

Action Plan Review

Photocopy for additional reviews

EHAP No.

Date of review: _____

Child/young person's full name: _____ Date of birth: _____

Lead Professional: _____ Tel: _____

Attendee (full name)	Role	Organisation/service	Tel

Were actions effective in achieving desired results? *(Number points in relation to action plan and use effectiveness rating below)*

Ineffective: No noticeable/measurable outcome/improvement. **Partly effective:** Small noticeable/measurable outcome, but still much to do to achieve the desired result. **Mostly effective:** Most of the desired result has been achieved. A little extra effort is needed to achieve/sustain all the desired results. **Completely effective:** Desired result achieved and can be maintained without further support.

Continuing needs and desired result (Number in order of priority)	**Further actions** (Indicate name/service)	**Desired completion date**

Date of next review meeting: _____

Consent for agreed further actions (if applicable) or closure of the EHAP

- ☐ I understand and agree with the proposed further action and consent to my information being shared with the services identified for the purpose of accessing these services.
- ☐ The desired results have been achieved and I consent to the EHAP closing.
- ☐ I no longer wish to continue with the EHAP and ask for it to be closed.

☐ EHAP closed by LP as level of need has escalated to Level 4/ statutory services.

Family comment on progress, agreed further actions or closure:

_____

_____

Full name (BLOCK CAPITALS): _____ Signature: _____ Date: _____

I am ☐ the young person (aged 12-16) ☐ the parent/carer of the child/young person ☐ the Lead Professional