WDF Member's Declaration Form 2016/2017

NMDS-SC ID

To be completed by each member of the partnership and returned to the lead partner for submission to Skills for Care

Your organisation's NMDS-SC registered name	
Your contact name	
Number of employees in these establishments	
CQC provider id **(must be completed or state not registered with CQC)**	
Main care service you provide	Choose an item
Name of partnership you are joining **Each establishment can only join 1 partnership**	
Your NMDS-SC registered address (including postcode)	
Phone number	
Your organisation's website address	
CQC location id for this service if applicable	
Email **(Email address must be completed or "no email" stated if you do not have an email address)**	

If your contact details are different from above please provide your details below

Address (including postcode)	
Phone number	
Email **(Email address must be completed or "no email" stated if you do not have an email address)**	

Member's Declaration

By joining this partnership my organisation understands that the grant holder is entering into a funding agreement on our behalf.

- I confirm that we are an adult social care employer and understand that we are only able to claim for staff and/or volunteers working within this organisation, for whom we have directly incurred costs for the specified qualification units, before we make a claim for funding.
- I understand that the Workforce Development Fund (WDF) is a contribution towards the costs of individuals in this organisation achieving relevant qualification units and that if this is combined with any other funding source, the total amount claimed will be equal to or less than the total cost incurred in achieving the units.
- I understand that I need to inform the grant holder of qualification units achieved and supply any relevant evidence/information that they need to claim the funding.
- I understand that I must keep clear and accurate records to evidence the funding spent and received for a period of 6 years and that I am required to supply information for audit purposes if requested by Skills for Care or a representative working on their behalf.
- I confirm that the evidence we supply in respect of WDF claims will be accurate and reliable.
- I understand that we have to fully complete and/or update the required National Minimum Data Set for Social Care (NMDS-SC) data on or after 1 April 2016 to be able to access WDF until 31 March 2017 and confirm that the account data will be an accurate reflection of our service(s) and workforce.
- I understand that funding claims for an establishment can only be made through one WDF partnership at any time. If I want to change partnerships I will resign from my existing partnership, complete a member's declaration form for the new partnership and Skills for Care will approve or decline the request.
- I will notify the grant holder if any of my establishments are no longer eligible to claim WDF.
- I understand that if we claim any funds that we are not eligible for then we will have to repay the value of these claims in full to the grant holder.

Name _____ Position in Organisation _____

Signature _____ Date _____

Please list all the establishments that are part of your organisation that you wish to claim funding for. Both parts of this form will need to be resubmitted if you wish to add new organisations throughout the year.

Name of establishment	Establishment address	NMDS-SC ID for this establishment	CQC location id if applicable

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