**SAS Programme Development Fund**

**Backfill / Additional Hours Costings Form**

Bids for backfill **MUST** include this form, which **must be completed by the applicant’s Health Board finance/ payroll section**. You must provide the dates of all planned attachments and any relevant on-call costs. Applications cannot be considered without this.

Payment for backfill and/or additional hours’ is limited to the applicant’s current rate of pay for their NHS substantive SAS grade appointment.

This supporting calculation must include:

1. **A payslip dated within the last 3 months**
2. **A pay report (ledger extract generated from the national payroll system) from the same period as the payslip**
3. A full breakdown of costs based on the applicant’s current monthly rate of basic pay
4. All employer’s on-costs (e.g. NI, Superannuation)
5. Any additional/other costs which may be associated with the application
6. The dates of **all** planned attachments

|  |
| --- |
| **TO BE COMPLETED BY APPLICANT BEFORE FORWARDING TO FINANCE SECTION** |
| **Applicant Name** |  |
| **Health Board** |  |
| **Dates of all planned attachments** |  |
| **Number of sessions requested per week** |  |
| **On-call to be covered? Yes/No** |  |
| **Is request for backfill AND / OR additional hours?** |  |

**REMAINDER OF FORM TO BE COMPLETED BY FINANCE/PAYROLL DEPT**

**BACKFILL**

|  |  |
| --- | --- |
| **BASIC MONTHLY PAY** |   |
| **OTHER** |   |
| **EPA/APA HOURS** |   |
| **AVAILABILITY SUPPLEMENT** |   |
|   |   |
|   |   |
| **TOTAL PAY** |   |
|   |   |
| **EMPLOYER NI** |   |
| **EMPLOYER SUPERANNUATION** |   |
|   |   |
|      **TOTAL COSTS**  |   |
|   |   |
| **TOTAL DURATION IN MONTHS** \* |   |
|  **TOTAL COSTS PER MONTH** |   |
|                                   **TOTAL AMOUNT CLAIMED** |   |

\*part months should be expressed as a fraction of a month (i.e.  7.25 = 7 months, 1 week)

**ADDITIONAL HOURS (if additional hours are not required please leave blank)**

|  |  |
| --- | --- |
| **BASIC MONTHLY PAY** |   |
| **OTHER** |   |
| **EPA/APA HOURS** |   |
| **AVAILABILITY SUPPLEMENT** |   |
|   |   |
|   |   |
| **TOTAL PAY** |   |
|   |   |
| **EMPLOYER NI** |   |
| **EMPLOYER SUPERANNUATION** |   |
|   |   |
|      **TOTAL COSTS**  |   |
|   |   |
| **TOTAL DURATION IN MONTHS** \* |   |
|  **TOTAL COSTS PER MONTH** |   |
|                                   **TOTAL AMOUNT CLAIMED** |   |

\*part months should be expressed as a fraction of a month (i.e.  7.25 = 7 months, 1 week)

|  |  |
| --- | --- |
| **TOTAL AMOUNT CLAIMED - BACK FILL + ADDITIONAL HOURS** |  |

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| **Please provide an explanation of and give evidence for ‘other’ costs:** |
|  |

**Please provide your information below:**

|  |  |
| --- | --- |
| **Name** |  |
| **Job title / department** |  |
| **Email address** |  |

**FOR INTERNAL NES USE ONLY**

**NES finance check:**

|  |  |
| --- | --- |
| **Name** |  |
| **Date** |  |
| **Email**  |  |

|  |
| --- |
| C**omments** |
|  |