Connecticut Medical Home Initiative for Children and Youth with Special Health Care Needs*
FAVOR
185 Silas Deane Highway
Wethersfield CT 06109
Tel: 860-436-6544 Toll Free: 855-436-6544
Fax: 860-563-3961 Email: CTMedicalHome@FAVOR-ct.org

PROGRAM APPLICATION

Date:	Referred by: FAVOR

Child's Information

Last Name:	First Name:

Sex ☐ M ☐ F	Birth Date: / /	Social Security # - - To be eligible for Respite funds or ESF this is required

Address:		
City:	State:	Zip Code:
Preferred Language:		

Race/Ethnicity

Hispanic ☐ YES ☐ NO

Race ☐ White ☐ Black ☐ Asian/Pacific Islander ☐ Native American ☐ Other (Specify)

Parent/Guardian Information

Name	Home phone #	Work phone #	Cell phone #	Best time to call
Mother:				
Father:				
Other:				

E-mail Address:

Does your child receive any of the following?

Social Security Income ☐ YES ☐ NO

☐ Husky A ☐ Husky B ☐ Husky B+ ☐ Husky C ☐ Katie Beckett Waiver ☐ Private Ins:

Husky Health Plan ID#	Private Health Plan ID#

Other Financial Support ☐ YES ☐ NO (if yes, please specify source*)____________________
(* i.e. Cystic Fibrosis Foundation, Pharmaceutical Subsidy, MDA, UCP, Lions' Club, Shriner's, etc.)

☐ Is your child over the age of 18? ☐ Is your Child a Full time student? ☐ Is your child employed?

☐ Does your child live out of the family home? ☐ Does your child attend a Day Program? ☐ Is your child on a wait list for a day program ?:

*The Connecticut Medical Home Initiative for Children and Youth with Special Health Care Needs is a program supported by the State of Connecticut Department of Public Health. Information is available on their website at www.ct.gov/dph/medicalhome

Mother's Information

Last Name:	Maiden Name:	First Name:	Birth Date: / /
Address:			Floor/Apartment:
City:	State:		Zip Code:
Social Security # - - Required for funding		Legal Guardian ☐ Yes ☐ No	
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow			
Employer:			
Employer's Address:			
Health Insurance:		Health Insurance ID #	
Health Insurance Phone #			
Health Insurance Mailing Address:			
City:		State:	Zip Code:

Father's Information

Last Name:	First Name:		Birth Date: / /
Address:			Floor/Apartment:
City:	State:		Zip Code:
Social Security # - -		Legal Guardian ☐ Yes ☐ No	
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed			
Employer:			
Employer's Address:			
Health Insurance:		Health Insurance ID #	
Health Insurance Phone #			
Health Insurance Address:			
City:		State:	Zip Code:

Contact information for legal guardian if other than the parent(s)

Last Name:		First Name:	Social Security # - -
Address:			Floor/Apartment:
City:	State:	Zip Code:	Guardian Relationship:

Family Income Information

Family Income	Amount	Annual Income	Amount
Child's Monthly SSI/SSDI		Father income OR SSI/SSDI	
Monthly Retirement		Mother income Or SSI/SSDI	
Monthly Alimony		Total Annual Income	
Monthly Child Support		Number of Children living in the house	
Monthly Temporary Family Assistance (TFA)		Number of Adults living in the house	
Other			

PLEASE ATTACH A COPY OF YOUR MOST RECENT TAX RETURN OR FOUR CONSECUTIVE PAYSTUBS AS PROOF OF INCOME

INFORMATION ON CHILD's SPECIAL HEALTH CARE AND MEDICAL NEEDS

Child's diagnosis(es)

1. Primary Diagnosis	
2. Secondary Diagnosis	
3. Other Condition	
4. Other Condition	

Child's Primary Health Care Provider

Provider's Name:		Phone #
Provider's Mailing Address:		
City:	State:	Zip Code:

Child's Dental Provider

Provider's Name:		Phone #
Provider's Mailing Address:		
City:	State:	Zip Code:

Child's Specialty Care Provider(s)

Specialist's Name	Specialty	Address	Phone #

2. Does your child have need of services that they are not currently receiving? ☐ Yes ☐ No (Example: Medication, Support Groups, Care Coordination, Special Education, Daycare or equipment etc.) If Yes, please describe:

3. If you have any matters or questions regarding your child that was not mentioned or covered by this form, please indicate below.

4. Names of other children with special health care needs in the family currently in this program.

For Office Use Only

Eligible for Extended Service Funds: ☐ YES ☐ NO If NO, Explain reason

Connecticut Medical Home Initiative for Children & Youth with Special Health Care Needs*
Screener and Complexity Index Tool

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<table>
<tr><td rowspan="7">Pediatric
Primary Care
Provider
Name
Address
Phone number
Fax
Email
To be inserted here</td><td>Child's Name (first)</td><td>(last)</td><td>Date of Birth:</td></tr>
<tr><td colspan="2">Sex: ☐ M ☐ F Race/Ethnicity:</td><td>Primary Diagnosis:</td></tr>
<tr><td colspan="2">☐ Parent ☐ Guardian:</td><td>Phone:</td></tr>
<tr><td>Address:</td><td>Town:</td><td>Zip:</td></tr>
<tr><td>Referrer:</td><td colspan="2">Primary Care Physician:</td></tr>
<tr><td colspan="3">Child's Insurance:</td></tr>
<tr><td colspan="3">Other Comments:</td></tr>
</table>

	Children and Youth with Special Health Care Needs (CYSHCN) Screener©FACCT	No	Yes (If yes, answer these questions) →	Is this because of ANY medical, behavioral or other health condition?	Is this a condition that has lasted or is expected to last for *at least* 12 months?
1	Does your child currently need or use medicine prescribed by a doctor (other than vitamins)?	☐	☐ →	Yes ☐ No ☐	Yes ☐ No ☐
2	Does your child need or use more medical care, mental health or educational services than is usual for most children of the same age?	☐	☐ →	Yes ☐ No ☐	Yes ☐ No ☐
3	Is your child limited or prevented in any way in his or her ability to do the things most children of the same age can do?	☐	☐ →	Yes ☐ No ☐	Yes ☐ No ☐
4	Does your child need or get special therapy, such as physical, occupational or speech therapy?	☐	☐ →	Yes ☐ No ☐	Yes ☐ No ☐
5	Does your child have any kind of emotional, developmental or behavioral problem for which he or she needs or gets treatment or counseling?	☐	☐	→	Yes ☐ No ☐

Connecticut Medical HOMES CYSHCN Complexity Index

Adapted from a similar tool developed by Exeter Pediatric Associates and the Center for Medical Home Improvement

Category	*Criteria (Score each Category 0, 1 or 2)*	*Score*
Hospitalizations, ER Usage and Specialty Visits (in last year)	0 = No service, activity or concern 1 = 1 hospitalization, ER or specialist visits for complex condition 2 = 2 or more hospitalizations, ER or specialist visits	
Office Visits and/or Phone Calls (in last year, over and above well-child visits)	0 = No service, activity or concern 1 = 1-2 Office Visits or MD/RN/care coordinator phone calls related to complex condition 2 = 3 or more office visits or MD phone calls	
Medical Condition(s): One or more diagnoses	0 = No service, activity or concern 1 = 1-2 conditions, no complications related to diagnosis 2 = 1-2 conditions with complications or 3 or more conditions	
Extra Care & Services at PCP office, home, school or community setting (see *Services*)	0 = No service, activity or concern 1 = One service from list below 2 = Two or more services from list below (*Services*: medications/medical technologies/therapeutic assessments/treatments/procedures and care coordination activities)	
Social Concerns	0 = No service, activity or concern 1 = "At risk" family/school/social circumstances 2 = Current/urgent complex circumstances	
Total Complexity Score		
DATE:	**Completed by:**	

1) Did the child get a Developmental Screening within the last year?

☐ Yes ☐ No ☐ Don't know ☐ Not Applicable

IF Yes: Was it confirmed by the provider? ☐ Yes ☐ No

Date parent asked question?________

Was it past or referred?____________

If referred, provider name:______________________________

Referral #2:______________________ Referral #3:______________________

Date parent asked question?___________

IF No: Where they referred for developmental screening? ☐ Yes ☐ No

What is your follow up plan?____

Date parent asked question?________________

2) Does the child have a diagnosis of asthma?

☐ Yes ☐ No Do they have an Asthma Action Plan(AAP)? ☐ Yes ☐ No

3) Does the parent have concerns about the child's weight (BMI)? ☐ Yes ☐ No

4) Does the child have BMI out of the normal range? ☐ Yes ☐ No ☐ High ☐ low ☐ Don't know

Weight: ________ Referred to:____

5A) Has the child been screened for mental/ behavioral health? ☐ Yes ☐ No

If No, was a referral made? ☐ Yes ☐ No To whom:_________________________

5B) Has the child been referred to mental/ behavioral health services ☐ Yes ☐ No ☐ Don't know

If Yes, was referred to ____

6) Does the child have a care plan? ☐ Yes ☐ No

If Yes- date completed:_________________________

Care Plan Needs Assessment ☐ Yes ☐ No

Care Plan Comprehensive? ☐ Yes ☐ No

Care Plan ER? ☐ Yes ☐ No

Care Plan Portable? ☐ Yes ☐ No

Other Care Plan ☐ Yes ☐ No

If no, who is responsible for creating a care plan? ______________________________

Enter date when completed _____________

7) Does this child need follow up?

☐ Need Supervisor Review ☐ Yes ☐ No ☐ N/A for converted case

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Attention Families:

Limited funds are available for families who have children and youth with special health care needs (CYSHCN) for **direct respite services.** The purpose of respite is to provide some relief to families caring for children and youth with special health care needs. These direct respite services are to be family directed, with the provider and the location of the respite services to be determined by family choice.

The limited respite funds will be awarded based upon family need.

To be considered eligible for Respite Service Funds:

1. **Fill out the Entire application including Respite Service Funds Form B , Request Form A, and the Children and Youth with Special Health Care Needs and Family Need Checklist attached to this letter. We need all 7 pages, as well as proof of income. You must include both parent and child's social security numbers , in order to be considered for funds. Please return all forms in the postage free envelope provided.**

For further information please contact: CT Medical Home Initiative at FAVOR: 855-436-6544

RESPITE SERVICE FUNDS REQUEST APPLICATION FORM A

Date	
Child's Name	
	Date of Birth:
Names of other children in the CYSHCN Program	
Parent's/Guardian's Name	
Parent's/Guardian's Social Security Number (Required)	
Address	
Town	**Zip code**
Phone Numbers (Daytime)	**(Evening)**
Best time to call	**EMAIL Address:**

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8/30/15

Connecticut Medical Home Initiative for Children and Youth with Special Health Care Needs*

Authorization for Release of Protected Health Information Form

I/We the undersigned hereby authorize any and all physicians, medical providers, medical facilities, therapists, schools, early intervention services, medical insurance companies, and any other health care professional or agency involved in my child's care to communicate with and/or release information, which may include information relating to medical, psychiatric, alcohol, and drug abuse, HIV/AIDS, Sickle Cell Disease, to any or all of the following:

Connecticut Medical Home Initiative for
Children and Youth with Special Health Care Needs
Eastern
United Community and Family Services, Inc.
47 Town Street
Norwich, CT 06360

Connecticut Medical Home Initiative for
Children and Youth with Special Health Care Needs
North Central
Connecticut Children's Medical Center
282 Washington Street
Hartford, CT 06106

Connecticut Medical Home Initiative for
Children and Youth with Special Health Care Needs
Northwest
St. Mary's Hospital, Inc.
95 Scovill St., Pavilion B, 2nd Floor
Waterbury, CT 06706

Connecticut Medical Home Initiative for
Children and Youth with Special Health Care Needs
South Central
Family Centered Services of Ct
235 Nicoll e St
New Haven, CT 06511

Connecticut Medical Home Initiative for
Children and Youth with Special Health Care Needs
Southwest
Stamford Hospital
30 Shelburne Road
Stamford, CT 06904

Connecticut Medical Home Initiative for
Children and Youth with Special Health Care Needs
CT Medical Home Initiative at FAVOR
185 Silas Deane Highway
Wethersfield, CT 06109

United Way of Connecticut 2-1-1 Infoline Child Development Infoline
1344 Silas Deane Highway
Rocky Hill, CT 06067

CT Medical Home Initiative for CYSHCN at
Generations Family Health Center Inc
42 Reynolds St, Danielson, Ct 06239
40 Mansfield Ave Willamantic,Ct 06226

Child's Name: ______________________ Date of Birth:

mm	dd	yy

Please specify the time period for the information you authorize to be disclosed:

☐ All information maintained at any time by the discloser, or

☐ Information maintained by the Discloser from:

mm	dd	yy

to:

mm	dd	yy

For the purpose of evaluation and/or care coordination –

The confidentiality of this record is required under Chapter 866 of the Connecticut General Statutes. The material shall not be transmitted to anyone without written consent or authorization as provided in the aforementioned statutes.

I may revoke this authorization at any time, except to the extent action has been taken in reliance thereon. This authorization, unless expressly revoked earlier, **expires on one year from date signed**. I understand that the information released here may be subject to re-disclosure by the recipient and may no longer be protected by the above-named facilities' privacy practices or applicable privacy law.

Signature:______________________ Date: ______________________

Signature: ______________________ Date: ______________________

If signed by the patient's personal representative, describe the legal authority of the representative to act on behalf of the patient:

____

I acknowledge the offer and/or receipt of the Notice of Privacy Practices from all current providers of care. (HIPAA)

Signature:______________________ Date: ______________________

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Connecticut Medical Home Initiative for Children and Youth with Special Health Care Needs *
Respite Family Needs Checklist

8/31/15

Complete this form if your child or youth has a *diagnosed* medical, behavioral, or physical need that requires more care and support than that of their peers.

Child's Name ______________________ **Parent Name**______________________**Child's Social Security #**______________
Address____ **Town/City**______________________ **State/ZIP**______________

Respite is care that is provided, in or out of the home, for the purpose of providing relief to the family/caregiver from the daily responsibilities of care for the child/youth with special health care needs. Respite services are family-directed, using the respite service provider and location of the family's choice.
Contact your care coordinator for more information about respite, ask for the Get Creative About Respite manual, or view it on-line at www.FAVOR-CT.org.

Caregivers available to meet needs	**Sources of community support during the past 12 months** *Check off all that apply*	**Sources of community support during the past 12 months** continued – *Check off all that apply*
___ Child or youth with special health care need has **more than one** significant physical, behavioral, or complex medical diagnosis.	___ Family receives **support or services** from the **Department of Children and Families (DCF).**	___ The child or youth has home health aides or nursing services on a weekly basis
___ **More than one** family member living in the home needs extra care and support. ______________________	___ Family receives **support or services** from the **Department of Developmental Services (DDS).**	___ The child or youth receives extended day services from school or a community group
___ Primary caregiver is in good health.	___ The child or youth receives **Voluntary Services from DCF or DDS.**	___ The family received camp funds in the last year from ______________
___ Primary caregiver is in poor physical or emotional health. ______________________	___ **The child received Birth to Three Services.**	___ The family received respite funds in the last year from______________
___ Number of adults available to help care for the child or youth with special health care needs.	___ The child or youth received respite services at a DDS Respite Center in the last year.	___ Received regular caregiver support from a community group or foundation
___ Total number of individuals living in the household	___ The family received a subsidized adoption.	___ Child has funding available from community group, SSI, or other groups or family sources. Please explain ______________________ ______________________
______________Total gross household income	___ The child or youth is on the Katie Beckett Waiver or other waiver.	Please list below any other information you wish to share. ______________ ______________________
	___ The child is enrolled in TRICARE ___ The Child is covered by Extended Care Health Option (ECHO).	