



**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		
<b>Child's Information</b>				
Last Name:		First Name:		
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Birth Date: / /	Social Security # - - - To be eligible for Respite funds or ESF this is required		
Address:				
City:		State:	Zip Code:	
Preferred Language:				
<b>Race/Ethnicity</b>				
Hispanic <input type="checkbox"/> YES <input type="checkbox"/> NO				
Race <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Native American <input type="checkbox"/> Other (Specify)				
<b>Parent/Guardian Information</b>				
Name	Home phone #	Work phone #	Cell phone #	Best time to call
Mother:				
Father:				
Other:				
E-mail Address:				
<b>Does your child receive any of the following?</b>				
Social Security Income <input type="checkbox"/> YES <input type="checkbox"/> NO				
<input type="checkbox"/> Husky A <input type="checkbox"/> Husky B <input type="checkbox"/> Husky B+ <input type="checkbox"/> Husky C <input type="checkbox"/> Katie Beckett Waiver <input type="checkbox"/> Private Ins:				
Husky Health Plan ID#		Private Health Plan ID#		
Other Financial Support <input type="checkbox"/> YES <input type="checkbox"/> NO (if yes, please specify source*) _____				
(* i.e. Cystic Fibrosis Foundation, Pharmaceutical Subsidy, MDA, UCP, Lions' Club, Shriner's, etc.)				
<input type="checkbox"/> Is your child over the age of 18? <input type="checkbox"/> Is your Child a Full time student? <input type="checkbox"/> Is your child employed?				
<input type="checkbox"/> Does your child live out of the family home? <input type="checkbox"/> Does your child attend a Day Program? <input type="checkbox"/> Is your child on a wait list for a day program ?:				

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### 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 <input type="checkbox"/> Yes <input type="checkbox"/> No	
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> 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:	
Social Security # - -		Legal Guardian <input type="checkbox"/> Yes <input type="checkbox"/> No
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed		
Employer:		
Employer's Address:		
Health Insurance:		Health Insurance ID #
Health Insurance Phone #		
Health Insurance Address:		
City:	State:	

### 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)**

<b>1. Primary Diagnosis</b>	
<b>2. Secondary Diagnosis</b>	
<b>3. Other Condition</b>	
<b>4. Other Condition</b>	

**Child's Primary Health Care Provider**

<b>Provider's Name:</b>		<b>Phone #</b>
<b>Provider's Mailing Address:</b>		
<b>City:</b>	<b>State:</b>	<b>Zip Code:</b>

**Child's Dental Provider**

<b>Provider's Name:</b>		<b>Phone #</b>
<b>Provider's Mailing Address:</b>		
<b>City:</b>	<b>State:</b>	<b>Zip Code:</b>

**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**

<b>Eligible for Extended Service Funds:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO <b>If NO, Explain reason</b>



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



Revised 1 2023

<b>Pediatric Primary Care Provider Name</b>  <b>Address</b>  <b>Phone number</b> <b>Fax</b> <b>Email</b> <b>To be inserted here</b>	Child's Name (first)	(last)	Date of Birth:	
	Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Unknown <input type="checkbox"/> Other:		Child's Preferred Pronouns:	
	Child's Race/Ethnicity:		<input type="checkbox"/> Parent <input type="checkbox"/> Guardian Name:	
	Address:		Town:	Zip:
	Phone:		Primary Language:	
	Child's Insurance:		Primary diagnosis:	
	Insurance ID#:		Referrer:	

<b>Children and Youth with Special Health Care Needs (CYSHCN) Screener©FACCT</b>		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 <u>at least</u> 12 months?
<b>1</b>	<b>Does your child currently need or use <u>medicine prescribed by a doctor</u> (other than vitamins)?</b>	<input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>2</b>	<b>Does your child need or use more <u>medical care, mental health or educational services</u> than is usual for most children of the same age?</b>	<input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>3</b>	<b>Is your child <u>limited or prevented</u> in any way in his or her ability to do the things most children of the same age can do?</b>	<input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>4</b>	<b>Does your child need or get <u>special therapy</u>, such as physical, occupational or speech therapy?</b>	<input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>5</b>	<b>Does your child have any kind of emotional, developmental or behavioral problem for which he or she needs or gets <u>treatment or counseling</u>?</b>	<input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

## 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
<b>H</b> ospitalizations, 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	
<b>O</b> ffice 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	
<b>M</b> edical 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	
<b>E</b> xtra Care & Services at PCP office, home, school or community setting (see <i>Services</i> )	0 = No service, activity or concern 1 = One service from list below 2 = Two or more services from list below ( <i>Services</i> : medications/medical technologies/therapeutic assessments/treatments/procedures and care coordination activities)	
<b>S</b> ocial Concerns	0 = No service, activity or concern 1 = "At risk" family/school/social circumstances 2 = Current/urgent complex circumstances	
<b>Total Complexity Score</b>		
<b>DATE:</b>	<b>Completed by:</b>	

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



Complete this form if your child or youth is *age 14 or under* and has a *diagnosed* medical, behavioral, or physical need that requires more care and support than that of their peers.

Child's Name \_\_\_\_\_ Parent Name \_\_\_\_\_ 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 <i>Complete each section</i>	Sources of community support during the past 12 months	Sources of community support during the past 12 months
<p><b><u>Section 1</u></b>            Child or youth with special health care need has <b>more than one</b> significant physical, behavioral, or complex medical diagnosis.  <b>and/or</b>  <b>More than one</b> family member living in the home needs extra care and support.</p> <p><b><u>Section 2</u></b>            Primary caregiver is in good health.  <b>or</b>            Primary caregiver is in poor physical or emotional health.</p> <p><b><u>Section 3</u></b>            Number of adults available to help care for the child or youth with special health care needs.  <b>and</b>            Total number of individuals living in the household  <b>and</b>            Total gross household income</p>	<p><b><u>Section 4</u></b> Check off all that apply</p> <p>Family receives direct funding from the Department of Children and Families (DCF).            _____</p> <p>Family receives direct funding from the Department of Developmental Services (DDS).            _____</p> <p>The child or youth receives Voluntary Services from DCF or DDS.            _____</p> <p>The child received Birth to Three Services.            _____</p> <p>The child or youth received respite services at a DDS Respite Center.            _____</p> <p>The family received a subsidized adoption.            _____</p> <p>The child or youth is on the Katie Beckett Waiver or other waiver.            _____</p> <p>The child is enrolled in TRICARE and the Extended Care Health Option (ECHO).            _____</p>	<p><b><u>Section 4 continued</u></b> Check off all that apply</p> <p>_____ The child or youth has home health aides or nursing services on a weekly basis</p> <p>_____ The child or youth receives extended day services from school or a community group</p> <p>_____ The family received camp funds from _____</p> <p>_____ The family received respite funds from _____</p> <p>_____ Received regular caregiver support from a community group or foundation</p> <p>Please list below any other information you wish to share.            _____            _____            _____</p>

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# Connecticut Medical Home Initiative (CMHI) for Children and Youth with Special Health Care Needs (CYSHCN)\*



## 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:

### CT Medical Home Initiative Children and Youth with Special Healthcare Needs Programs:

- North Central Region: Connecticut Children's Medical Center, Center for Care Coordination
- Eastern Region: United Community and Family Services, Inc.
- Eastern Region: Generations Family Health Center, Inc
- Northwest Region: St. Mary's Hospital, Inc.
- South Central Region: Family Centered Services of CT
- Southwest Region: Stamford Hospital
- CT Medical Home Initiative at FAVOR

### Other:

- United Way of Connecticut 2-1-1 Infoline Child Development Infoline
- \_\_\_\_\_

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 Connecticut General Statutes 19a-25. 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: \_\_\_\_\_

\*The CMHI for CYSHCN is a program supported by the State of CT Department of Public Health. Information is available on their website at [www.ct.gov/dph/medicalhome](http://www.ct.gov/dph/medicalhome) . Revised 1.2023



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Fax: 860-563-3961 Email: CTMedicalHome@FAVOR-CT.org**

**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**

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

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