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	Cell Phone #	Work phone #	Home phone #	E-mail Address
Mother:				
Father:				
Other:				

Preferred Method of Communication: ☐Mail ☐Email

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 ?:

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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 ☐ 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

Revised 10.2023

Pediatric Primary Care Provider Name	Child's Name (first)	(last)	Date of Birth:
	Sex: ☐ M ☐ F ☐ Unknown ☐ Other:	Child's Preferred Pronouns:	
Address	Child's Race/Ethnicity:	☐ Parent ☐ Guardian Name:	
Phone number	Address:	Town:	Zip:
Fax	Phone:	Primary Language:	
	Child's Insurance:	Primary diagnosis:	
Email	Insurance ID#:	Referrer:	

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:**	

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DPH

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. Revised 11 2020

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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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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 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.EAOR-CT.ORG

Caregivers available to meet needs
Complete each section

Section 1

___ Child or youth with special health care need has **more than one** significant physical, behavioral, or complex medical diagnosis.

and/or

___ **More than one** family member living in the home needs extra care and support.

Section 2

___ Primary caregiver is in good health.

or

___ Primary caregiver is in poor physical or emotional health.

Section 3

___ Number of adults available to help care for the child or youth with special health care needs.

and

___ Total number of individuals living in the household

and

_____ Total gross household income

Sources of community support during the past 12 months

Section 4 *Check off all that apply*

___ Family receives support or services from the Department of Children and Families (DCF).

___ Family receives support or services from the Department of Developmental Services (DDS).

___ The child or youth receives Voluntary Services from DCF or DDS.

___ The child received Birth to Three Services.

___ The child or youth received respite services at a DDS Respite Center.

___ The family received a subsidized adoption.

___ The child or youth is on the Katie Beckett Waiver or other waiver.

___ The child is enrolled in TRICARE and the Extended Care Health Option (ECHO).

Sources of community support during the past 12 months

Section 4 continued *Check off all that apply*

___ The child or youth has home health aides or nursing services on a weekly basis

___ The child or youth receives extended day services from school or a community group

___ The family received camp funds from _____

___ The family received respite funds from _____

___ Received regular caregiver support from a community group or foundation

Please list below any other information you wish to share. _____

_____

_____

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