NOTICE FOR EXPEDITED REVISIONS TO AGENCY FORMS

Proposed Expedited Revision Number **2022-5** Form Number **(Not applicable)**

1. Agency Name & Address: **Dept. of Health & Human Services** **Bureau for Family Centered Services** **Division of Long Term Supports & Services** **129 Pleasant St., Thayer Building** **Concord, NH 03301**	2. RSA Authority: **RSA 132:10-b,IV** 3. Federal Authority:

4. Short Title: **Expedited Revisions to the "Special Medical Service (SMS) – Application for All Services"**

5. Explanation of the reason for the proposed readoption with amendment of the form:

The Department of Health and Human Services (Department) proposes to readopt with amendment, through the expedited revisions to forms process, pursuant to RSA 541-A:19-c, the following form with the new edition date noted:

- **The formerly titled "Special Medical Services (SMS) – Application for All Services" as amended with new title "Bureau for Family Centered Services (BFCS) – Application for Services", April 2022 Edition, incorporated by reference in He-M 520.02(a).**

The "Special Medical Services (SMS) – Application for All Services" has been further amended as follows:

- **Changed the application name from "Special Medical Services – Application for All Services" to "Bureau for Family Centered Services (BFCS) – Application for All Services";**
- **Removed program descriptions on page one;**
- **Edited verbiage for clarity and consistency with data system utilized by program staff;**
- **Removed the financial assistance section as this is an optional service and not required to be in the application;**
- **Removed the Partners in Health (PIH) Family Assessment as this is not required to be in the application; and**
- **Other minor editorial changes.**

6. Contact person for copies and questions about the proposed form:

Name:	**Nicole Burke**	Title:	**Administrative Rules Coordinator-Administrative Rules Unit**
Address:	**Dept. of Health & Human Services** **Administrative Rules Unit** **129 Pleasant Street, Brown Bldg.** **Concord, NH 03301**	Phone #: Fax#: E-mail:	**(603) 271-9640** **(603) 271-5590** **Nicole.V.Burke@dhhs.nh.gov**

TTY/TDD Access: Relay NH 1-800-735-2964 or dial 711 (in NH)

7. Deadline for submission of materials in writing or in the electronic format specified:
Thursday, April 7, 2022

☒Fax ☒E-mail ☐Other format (specify):

CONSENT

Readopt with amendment "Special Medical Services (SMS)" (December 2018), incorporated by reference in He-M 520.02(a), effective 12-28-18 (Document #12699), with the new title "Bureau for Family Centered Services (BFCS) – Application for Services", April 2022 Edition.

In addition to reformatting the form, the "Special Medical Services (SMS) – Application for All Services" has been further amended as follows:

- Changed the application name from "Special Medical Services – Application for All Services" to "Bureau for Family Centered Services (BFCS) – Application for All Services";
- Removed program descriptions on page one;
- Edited verbiage for clarity and consistency with data system utilized by program staff;
- Removed the financial assistance section as this is an optional service and not required to be in the application;
- Removed the Partners in Health (PIH) Family Assessment as this is not required to be in the application; and
- Other minor editorial changes.

BUREAU FOR FAMILY CENTERED SERVICES (BFCS)
APPLICATION FOR SERVICES
Please complete each section with the most current information*
If applicant is 18 or older, their signature is required on all forms. If applicant has a guardian, submit a copy of legal documents.

Applicant Information

Applicant Name:_____ **Date of Birth:** _____ **Age:** _____

Residence Address: _____

Mailing Address (if different): _____

Primary Phone: _____ **Secondary Phone:** _____

Primary Email: _____ **Secondary Email:** _____

Sex assigned at birth: ☐ **Male** ☐ **Female** ☐ **Choose not to disclose**

Applicant's Race and Ethnicity

Are you Hispanic, Latino/a, or of Spanish origin

☐ No, not of Hispanic, Latino/a, or Spanish origin.
☐ Yes, Puerto Rican.
☐ Yes, Cuban.
☐ Yes, Mexican, Mexican American, Chicano/a.
☐ Yes, another Hispanic, Latino/a, or Spanish origin.

What is your race?

☐ White
☐ Black or African American
☐ American Indian or Alaska Native
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian
☐ Native Hawaiian
☐ Guamanian or Chamorro
☐ Samoan
☐ Other Pacific Islander

Primary LanguageSpoken at home: _____ **Interpreter needed for:** ☐ Spoken ☐ Written ☐ ASL

US Citizen: ☐ Yes ☐ No **Legal Resident:** ☐ Yes ☐ No

Household Information - Those who reside in the same home with applicant (check all that apply)

Applicant resides at home with their:

☐ Married parents ☐ Single parent ☐ Guardian or foster parents ☐ Unmarried parents/adults ☐ Grandparent(s)
☐ Applicant is an adult (18 years or older) ☐ Applicant is married ☐ Applicant does not live with parents/guardians

Parent/Guardian Name: _____ **Parent/Guardian Name:** _____

Siblings under age 18 residing in home

Number of siblings under the age of 18 residing in home _____ Number of siblings enrolled with BFCS _____

Please lists siblings enrolled in BFCS programs. Please check if enrolled with Special Medical Services (SMS) or Partners in Health (PIH)

Name: _____Age: _____ ☐ SMS ☐ PIH Name: _____Age: ____ ☐ SMS ☐ PIH

Name: _____Age: _____ ☐ SMS ☐ PIH Name: _____Age: ____ ☐ SMS ☐ PIH

Please attach list with any additional names.

Other Services in which Applicant is CURRENTLY enrolled and ACTIVELY receiving

☐ Social Security Payments ☐ Special Education ☐ Partners in Health (PIH) ☐ Other Special Medical Services (SMS)
☐ Area Agency ☐ Early Supports & Services ☐ WIC

Health Insurance Information

Medicaid: ☐ Yes ☐ No ☐ Pending Medicaid Number: _____

Managed Care Organization (MCO): _____ MCO Number_____

Other Insurance Name: _____ Policy Number :_____ Group ID:_____

Subscriber:_____ Subscriber's Date of Birth:_____ Relation:_____

BFCS services being requested (check all that apply)

☐ Health Care Coordination ☐ Complex Care Consultation ☐ Partners in Health
☐ Child Development Evaluation ☐ Nutrition, Feeding and Swallowing
☐ Other (explain): _____

Current Diagnoses

Diagnoses _____

_____

_____

Referred by:

☐ Primary care physician (MD/FP/NP).
☐ Other type of health care provider
☐ Out of state specialty program
☐ Medical specialist
☐ School district/School nurse
☐ Early Supports and Services
☐ Nutrition or Feeding/Swallowing program
☐ Area Agency
☐ Home/public health
☐ Hospital
☐ Partners in Health
☐ Parent
☐ Friend
☐ VNA
☐ Special Medical Services
☐ NH Family Voices
☐ Other

_____

_____

Applicants Providers and Services

PROVIDER/SPECIALIST	PROVIDER NAME	OFFICE / ADDRESS	TELEPHONE
Primary Care Provider /PCP			
Specialist			
Specialist			
Specialist			
Dentist			
Early Supports and Services			
Special Educator/Teacher			
Speech Therapist			
Physical Therapist			
Occupational Therapist			
School Nurse			
Area Agency			
Home Care Services			
Equipment Vendors			

Thank you for completing the BFCS application.

_____ _____ _____

Print Name *Parent, Guardian or Self (if age or older)* **Signature (***Parent, Guardian, or Self (if age18 or older)* **Date Signed**

The signature above shall attest that all information provided in the application is true and correct to the best of my knowledge. I realize that any intentional misrepresentation may result in legal action against me since BFCS receives its funds from state and federal sources. I also realize the BFCS may use other state data or resources to verify the information provided in this application.

Return Signed Application to: DHHS/BFCS , 129 Pleasant St, Thayer Bldg., Concord NH 03301 or BFCS@dhhs.nh.gov

The State of New Hampshire Department of Health and Human Services does not discriminate because of race, creed, color, sex, age, political affiliation, religion, national origin, or handicap. There will be no unlawful discrimination in accepting or providing services.

Special Medical Services (SMS)

NH Title V Program for Children & Youth With Special Health Care Needs

SMS offers health programs and services for children ages birth to 21 years, who have, or are at risk for, a chronic medical condition, disability or special health care need, and their families.

SMS SERVICES ARE AT NO COST TO FAMILIES

Please complete the SMS application and check off the boxes for which services are requested.

Types of Services provided by SMS

Health Care Coordination

Specialized health care coordinators partner with families to plan for and obtain needed medical and related services for their child with a chronic medical condition and/or disability. Health Care Coordinators assess and monitor health care needs by connecting with families, health care providers, community agencies, and schools. They support families and can help them to find and use social, psychological, educational, medical, and financial resources as needed.

Neuromotor Clinic

Provides a specialized clinical team approach with scheduled clinic visits and health care coordination (see above) for children with physical disabilities associated with significant orthopedic, neurological, muscular, and motor coordination delays.

Nutrition, Feeding and Swallowing Program

Provides a statewide network of pediatric dieticians and feeding & swallowing providers who offer in-home and community based consultation and evaluation.

Family Support Services through Partners in Health (PIH) (attach separate PIH Family Assessment)

Family support coordinators work with families to make and reach individual goals. The goals help families manage the impact of a child's chronic health condition and to improve home, school, and community settings. Families have access to resources, funds, support groups, education, social

Complex Care Network

A consultative model to evaluate children with chronic and complex health conditions, who would benefit from assistance addressing their health concerns and educational needs. The one time evaluation can be with an individual provider, as a group consultation, or a clinic appointment. The team consists of a developmental pediatrician, physical therapist, educator and feeding and swallowing specialist as appropriate.

Child Development Clinic

Comprehensive one time diagnostic evaluation to assist families who have children with developmental and behavioral concerns/differences. Clinic Evaluators will assist families in making informed decisions regarding medical, developmental and educational needs.

Optional Service

Financial Assistance :Financial assistance means payment for health related services according to the SMS fee schedule. Attach the financial assistance page and documentation to be reviewed for services.

*All applications are reviewed within 60 days to determine if the applicant meets the eligibility requirements for the programs requested.

*Once an application has been reviewed, a mailed notification of eligibility followed up with phone contact from a program coordinator to discuss the SMS program(s) enrollment availability for the applicant.

*If you have additional questions or concerns about the application or SMS services, call our toll-free number 1-800-852-3345 ext. 4488.

SPECIAL MEDICAL SERVICES (SMS) - APPLICATION FOR ALL SERVICES

APPLICATION FOR ☐ Child Under 18 ☐ Self (age18 +)

Please complete each section with the most current information*

If applicant is 18 + their signature is required on all forms, if applicant has a guardian , submit a copy of legal document.

Applicant Information

Applicant Name **Date of Birth** **Age** **Gender**

Residence Address

Mailing Address

Primary Phone **Secondary Phone**

Primary E-Mail **Secondary E-Mail**

Applicants Race and Ethnicity

☐ Not of Hispanic, Latino/a, or Spanish Origin	☐ White	☐ Filipino	☐ Japanese
☐ Puerto Rican	☐ Black or African American	☐ Vietnamese	☐ Korean
☐ Cuban	☐ American Indian / Alaska Native	☐ Samoan	☐ Native Hawaiian
☐ Mexican, Mexican American, Chicano/a	☐ Asian Indian	☐ Other Asian	☐ Chinese
☐ Another Hispanic, Latino/a, or Spanish Origin	☐ Other Pacific Islander	☐ Guamanian or Chamorro	

Household Information - Those who reside in the same home with applicant (check all that apply)

Primary Language Spoken **Interpreter Needed** ☐ Yes ☐ No ☐ With Forms

US Citizen ☐ Yes ☐ No ☐ Legal resident Alien

Applicant resides in this type of household (with adults listed as 1&2):

☐ Married ☐ Single Parent ☐ Not in Parents Home ☐ Unmarried & Common Child ☐ Self (18+)

Adult's relationship to the applicant is:

☐ Parent ☐ Guardian ☐ Grandparent ☐ Adoptive ☐ Foster ☐ Self (18+ /unmarried)

Adult 1 Name **Adult 2 Name**

Siblings in Home (under age 18)

Name: Age: ☐ SMS ☐ PIH Name: Age: ☐ SMS ☐ PIH

Name: Age: ☐ SMS ☐ PIH Name: Age: ☐ SMS ☐ PIH

How many Siblings under 18 reside in home **Number of Siblings under 18 enrolled in SMS**

*Other Services Applicant is **CURRENTLY** Enrolled **& ACTIVELY** Receiving*

☐ **SSI Payments** ☐ **Area Agency** ☐ **Special Education** ☐ **Early Supports & Services**

☐ **PIH** ☐ **WIC** ☐ **SMS**

Insurance Information

Medicaid ☐ Yes ☐ No **Medicaid Number** _____

MCO **MCO #**

Insurance Name **Policy #** **Group ID**

Subscriber **DOB** **Relation**

SMS Services Requested (new or currently enrolled)

☐ Health Care Coordination ☐ Neuromotor Clinic ☐ Nutrition, Feeding & Swallowing Services

☐ Child Development Evaluation ☐ Complex Care Network ☐ Partners in Health/Family Support *(attach the PIH family assessment with application)*

☐ Other *(explain)* _____

Current Diagnosis

Diagnosis Description: _____

Program Referral Information

☐ Primary Care Physician (MD/FP/NP) ☐ Medical Specialist ☐ Area Agency ☐ Hospital

☐ Other Type of Health Care Provider ☐ School District/Nurse ☐ Nutrition Program ☐ PIH

☐ Out of State Specialty Program ☐ Early Supports & Services ☐ Home/ Public Health ☐ Parent/Friend

Name of Referral Agency & Person

Applicants Providers and Services (*please complete to the best of your knowledge)*

PROVIDER/ SPECIALIST	PROVIDER NAME	OFFICE / ADDRESS	TELEPHONE
Primary Care Provider /PCP			
Specialist			
Physician/Specialist			
Physician/Specialist			
Physician/Specialist			
Dentist			
Early Supports and Services			
Special Educator/Teacher			
Speech Therapist			
Physical/Occupational Therapist			
School Nurse			
Area Agency			
Home Care Services			
Equipment Vendors			

You have completed the SMS application, application is valid for all SMS programs for 1 year from the signature date. *

Print Name*(Parent /Guardian/Self if age18+)*

Signature ***(****Parent /Guardian/Self if age18+)*

Date Signed

The signature above shall attest that all information provided in the application is true and correct to the best of my knowledge I realize that any intentional misrepresentation may result in legal action against me since SMS receives its funds from state and federal sources. I also realize the SMS may use other state data or resources to verify the information provided in this application.

Return Signed Application to: DHHS/Special Medical Services, 129 Pleasant St, Thayer Bldg, Concord NH 03301

The State of New Hampshire Department of Health and Human Services does not discriminate because of race, creed, color, sex, age, political affiliation, religion, national origin, or handicap. There will be no unlawful discrimination in accepting or providing services.

SMS Financial Assistance (optional service requested)

SMS offers financial assistance to help with some medical bills. Assistance is after all other insurance and resources have been exhausted. Eligibility for assistance is determined using HH income and resources. Payments made are at NH Medicaid rates and must support/be related to the applicant's medical diagnosis.

Household	Applicant	Adult 1	Adult 2
Name of person whose income you are reporting			
Gross Earned Income (Monthly Total) *Provide Verification or written statement to support information as reported*			
Employed: Total gross amount of the last /current month of pay (weekly~ 4 pay stubs or Bi-weekly ~2 pay stubs) **OR**			
Self-Employed: Last Year's 1040 Tax Form; Schedule C			
Unearned Income (Monthly Total) *Provide Verification or written statement to support information as reported*			
Social Security/Disability (SSI/SSA)			
Child Support/Alimony Received/Rental			
Unemployment Compensation (Copy of check)			
Cash Assistance (i.e. TANF /FAP/APTD/ANB)			
Pension/VA Benefits			
Dividends/Interest (trust/annuity/settlement)			
Current Balance of Accessible Resources *Provide Verification or written statement to support information as reported*			
Checking Accounts			
Savings			
Stocks/Savings Bonds /CD's/Mutual Funds			
Trust Funds (copy is required EXCEPT a SNT)			
Out of Pocket Expenses (Monthly Total) *Provide Verification or written statement to support information as reported*			
Health or Dental Insurance Premiums:			
Court Ordered Child Support (Paid outside the HH)			
Household Child Care Expenses			
Specialty Diet Foods for Medical Condition			

Print the name of the Parent /Guardian _____ Signature of the Parent /Guardian _____ Date Signed _____

The signature above shall attest that all information provided in the SMS Application is true and correct to the best of my knowledge. I realize that any intentional misrepresentation may result in legal action against me since Special Medical Services receives its funds from state and federal sources. It also confirms my understanding that SMS may use other state data or resources to verify the information provided in this application.

Partners in Health (PIH) Family Assessment

Impact of Health Condition

Is the condition expected to last 1 year or more?	☐	Yes	☐	No
Condition requires frequent PCP/ Specialist visits	☐	Yes	☐	No
Significantly impacts the daily emotional, social & physical functions	☐	Yes	☐	No
Significantly impacts the daily family, school &community functions	☐	Yes	☐	No

Household Expense

Type of Housing ☐ Own Home ☐ Rental ☐ Rental Assisted ☐ Shared ☐ Homeless

Type of Utility

Phone Type ☐ Cell ☐ Home Line *Electric* ☐ Yes ☐ No

Heating Type ☐ Gas/Propane ☐ Wood/Pellet ☐ Oil

Transportation ☐ Own Car ☐ Borrowed Car ☐ Friend/Family ☐ Public *(bus/taxi/uber)*

Assessment:

List family's Needs, Goals, Strengths with responsible person and time frame to complete