Doc. #13370, (eff 4-20-22)

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

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