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 copy of legal documents.

Applicant Information

Applicant Name:_____ Date of Birth:_____Age: _____
Residence Address:_____
Mailing Address:_____
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 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, Latina/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 language spoken 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 the 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 or older) ☐ Applicant is married ☐ Applicant does not live with parents/guardians

Parent/Guardian name:_____ **Parent/Guardian name:**_____

Siblings in home under the age of 18

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 applicant is CURRENTLY enrolled and ACTIVELY receiving

☐ Social Security Payments ☐ Special Education Services ☐ Partners in Health ☐ Special Medical Services

☐ Area Agency ☐ Early Supports and 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

☐ Health Care Coordination ☐ Complex Care Network ☐ 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
☐ Area Agency
☐ Nutrition program
☐ Home/public health
☐ Hospital
☐ Partners in Health
☐ Parent
☐ Friend
☐ VNA
☐ Special Medical Services
☐ NH Family Voices
☐ Other _____

Applicant's providers and services

PROVIDER/SPECIALIST	PROVIDER NAME	OFFICE/ADDRESS	TELEPHONE
Primary care provider			
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/self (18 or older) **Signature** Parent/guardian/self (18 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: BFCS, 129 Pleasant St– Thayer, 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.