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

Legal Resident of the US: ☐ 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.

Name: _______________________Age: _____ Name: _______________________Age: ____
Name: _______________________Age: _____ Name: _______________________Age: ____

Other services applicant is CURRENTLY enrolled and ACTIVELY receiving

☐ Social Security Disability ☐ Early Supports and Services ☐ WIC ☐ Complex Care Network

☐ Area Agency ☐ Nutrition, Feeding, Swallowing ☐ Child Development evaluation ☐ Health Care Coordination

☐ Special Education Services

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
☐ Child Development Evaluation
☐ Nutrition, Feeding and Swallowing
☐ Other (explain) ____

Current Diagnoses

Diagnoses:____
____

Referred by:

☐ Primary care physician (MD/APRN/DO)
☐ Other health care provider (not PCP)
☐ Out of state specialty program
☐ Medical specialist
☐ School district/ School nurse
☐ Early Supports and Services
☐ Area Agency
☐ SSI/HC-CSD Outreach
☐ Newborn Screening Program
☐ Home health/VNA
☐ Hospital
☐ Parent/guardian/self
☐ Friend
☐ Child care/Head Start program
☐ NH Family Voices
☐ Other community agency (specify) ______________________
☐ Other (specify) ______________________

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

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