**Special Medical Services (SMS)**
**New Hampshire Title V Program for Children With Special Health Care Needs**

**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.**

Please Complete Application and additional pages for the following Services provided by SMS:

**Health Care Coordination** (complete SMS application, pages 1-4)

- 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** (complete SMS application, pages 1-4)

- 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** (complete SMS application, pages 1-4 and attach separate NFS questionnaire)

- 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)~** (complete SMS application, pages 1-4 and attach separate PIH questionnaire)

- 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 activities, and leadership activities.

**SMS services are at no cost to families**

- All applications are reviewed within 30 days to determine if your child or youth (the applicant) meets the eligibility requirements for the programs requested. Once an application has been reviewed, a SMS Coordinator will contact you to discuss how SMS can help you and your child.
- If you have additional questions or concerns about the application or our services, you may call our toll-free number 1-800-852-3345 ext. 4488 for further assistance.

# SPECIAL MEDICAL SERVICES (SMS) ~APPLICATION FOR ALL SERVICES

***APPLICATION IS:*** ☐ *NEW* **OR** ☐ *UPDATE* ***FOR A*** ☐ **CHILD (0-17)** ☐ **SELF (18-21)**

**Applicant Name:** _____ **Date Of Birth:** _____ **Sex:** ☐M ☐F
Last MI First

**Applicant Residence:** _____ _____ NH _____
Street Address Town/City Zip

**Mailing Address (if not the same as residence):** _____ _____ NH _____
Street Address Town/City Zip

**Primary Contact Phone:** _____ **Second Phone:** _____ **E-Mail:** _____

**Ethnicity:** (One or more categories may be selected)
**Are you Hispanic, Latino/a, or Spanish origin?**

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

**Race:** (One or more categories may be selected)
**What is your race?**

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

**Applicant is a US Citizen or Legal Resident Alien** ☐ **Yes** ☐ **No** ☐ **Other** _____

**Primary Language Spoken:** ☐ English ☐ Spanish ☐ Other _____

**Use/Need An Interpreter?** ☐ No ☐ Yes/ for Verbal Language(above) ☐ Yes /for Forms ☐ Yes /Deaf ☐ Yes/Other

**Applicant is either ( Self 18+) or resides in this type of Household :** (Check one )

☐ Self (18 +) ☐ Legal Guardian/Foster Parent ☐ Married ☐ Single Parent ☐ Divorced ☐ Separated ☐ Widowed

***List Information below about those who reside with the applicant***

| **Parent/Guardian ~1** | | | | **Parent/Guardian ~2** | | | |
|---|---|---|---|---|---|---|---|
| **Name:** | | | | **Name:** | | | |
| Contact Phone | ☐ | Same as above | | Contact Phone | ☐ | Same as above | |
| E-mail | ☐ | Same as above | | E-Mail | ☐ | Same as above | |

**Siblings~ *Who Reside With The Applicant***

| Name | Sex | Age | Is Enrolled | Name | Sex | Age | Is Enrolled |
|---|---|---|---|---|---|---|---|
| | | | ☐SMS☐PIH | | | | ☐SMS☐PIH |
| | | | ☐SMS☐PIH | | | | ☐SMS☐PIH |

## PRIMARY CARE

Name of Primary Doctor: _____ Office Name: _____

## SERVICES RECEIVED

☐ SSI Payments ☐ Area Agency ☐ Early Supports & Services ☐ Family Support ~ PIH ☐ WIC ☐ SMS

## HEALTH INSURANCE

**NH Medicaid Status** ☐ Open/Active ☐ Pending Application ☐ Don't Have ☐ Never Applied

Medicaid ID #: _____ Medicaid Managed Care (MCO) Organization: _____

**Private/Other Health Insurance Status** ☐ Currently Have ☐ Don't Have Private Insurance

**Name Of Insurance Company:** _____

Insurance Mailing Address: _____ Phone Number: _____

Insurance ID #: _____ Group ID #: _____

Subscriber Name: _____ Subscriber's Birth Date: _____

Subscriber's Relationship to Applicant: ☐ Mother ☐ Father ☐ Other _____

## SERVICES

**Which services are you requesting?**
☐ **HEALTH CARE COORDINATION** ☐ **NUTRITION** ☐ **FEEDING & SWALLOWING**
☐ **NEUROMOTOR CLINIC** ☐ **FAMILY SUPPORT – Partners in Health**

**Who referred you?** ☐ Physician/PCP/MD/Nurse ☐ Medical Specialist ☐ Hospital ☐ Early Supports & Services
☐ Self Referral ☐ School ☐ Area Agency ☐ Friend/Neighbor ☐ SMS/NFS ☐ Partners in Health
☐ Other _____

**Name of person who referred:** _____

**Why you were referred:** _____

**List all Medical Diagnoses of Applicant:** _____

# AUTHORIZATION FOR RELEASE & EXCHANGE OF PERSONAL HEALTH INFORMATION(PHI)

Special Medical Services

Patient's Legal Name: _____ (Last Name) _____ (MI) _____ (First) DOB: _____

Residence Address: _____ (Street/Apt) _____ (Town/City) _____ (State) _____ (Zip)

Primary Phone _____ Other Phone _____

| Type of Protected Health Information (PHI) requested | Name and Address of Office to obtain requested information |
|---|---|
| Birth Records (Child <12 months old) | |
| Growth Charts /Laboratory reports | |
| PCP~ Progress and/or Office notes | |
| Specialist ~Progress and/or Office notes | |
| Evaluations /Therapy Notes /Speech, Physical or Occupational | |
| School Records ~ IFSP /IEP | |
| Other Specified Person or Agency to release PHI from | |

**PURPOSE OF DISCLOSURE:** ongoing care and treatment

Please Read the Following Statements **CAREFULLY** and initial only if applicable:

_____ I understand the medical record may contain information in reference to drug and/or alcohol abuse which is protected by law and is prevented from re-disclosure without my expressly written consent or otherwise permitted by law.

_____ I specifically authorize release of HIV, AIDS or ARC results or treatment

_____ I specifically authorize release of psychiatric or neuropsychiatry record.

**EXPIRATION** :This authorization will expire:

**On** _____ *If no date is specified, this authorization shall expire 12 months from the date it was signed*

**REVOCATION** I understand that I may revoke this authorization at any time, by notifying DHHS in writing, except to the extent that any actions initiated in reliance on the authorization may have been completed prior to my revocation.

_____ Date Signed: _____

Applicant or Legal Representative Signature

Authority of Signature ☐ Applicant (18+) ☐ Parent of Minor ☐ Guardian ☐ Other _____

****A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AS THE ORIGINAL****

*The HIPAA Privacy Rule defines a health oversight agency to include a Federal or other governmental agency or authority that is authorized by law to oversee the health care system (whether public or private), or government programs in which health information is necessary to determine eligibility or compliance with program standards (45 CFR 164.501). Oversight agencies also include a person or entity acting under a contract with the public agency. Under 42 CFR 164.512(d), a covered entity may disclose protected health information to a health oversight agency without the patient's permission for oversight activities authorized by law, including oversight of compliance with program standard.*

**Please complete to the best of your knowledge**

| Provider/Specialty of provider | | Provider /Person Name | Office Name /Town | Telephone |
|---|---|---|---|---|
| Primary Care Provider | PCP | | | |
| Specialist | | | | |
| Physician/Specialist | | | | |
| Physician/Specialist | | | | |
| Physician/Specialist | | | | |
| Dentist | | | | |
| **School/Early Supports and Services** | | | | |
| Early Supports and Services | | | | |
| Special Educator/Teacher | | | | |
| Speech Therapist | | | | |
| Physical /Occupational Therapist | | | | |
| School Nurse | | | | |
| **Community Based Services** | | | | |
| Area Agency | | | | |
| Family Support Services-PIH | | | | |
| Home Nursing Services | | | | |
| Equipment Vendors | | | | |

***You have now completed the SMS application, please sign below.***

| *Print Name of person who completed the application* | *Your Signature* | *Relationship to Applicant* | *Date Completed* |
|---|---|---|---|
| | | | |

The applicant's 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.

**Mail All Applications to:** DHHS/Special Medical Services, 129 Pleasant St, Thayer Bldg, Concord NH 03301

**If requesting, attach questionnaire for** ☐ Nutrition, Feeding & Swallowing ☐ Family Support (PIH) ☐ Financial Assistance

*℘ 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.*