NEW HAMPSHIRE
DEPARTMENT OF HEALTH & HUMAN SERVICES
DIVISION OF COMMUNITY BASED CARE SERVICES
BUREAU OF DEVELOPMENTAL SERVICES
SPECIAL MEDICAL SERVICES

SMS Special Medical Services

(Office use only)

Partners In Health: Family Support Services
Health Care Provider Diagnosis Verification Form

The NH Partners in Health Program (PIH) provides social support to families of children aged 0-21 years with chronic health conditions or young adults themselves, regardless of income.

Applicant Information: ☐Child (0-21) ☐Young Adult (18-21, applying as own family)

Name: Date of Birth:
(First) (Middle) (Last)

Child/Young Adult's Diagnosis

Please check yes or no to the following statement.

YES	NO	
☐	☐	The child/young adult has a developmental disability.

The Partners in Health Program per He-M 523 defines a chronic health condition to NOT include a developmental disability, mental illness, dental condition, or obesity alone. ***Please list and describe the impact and ICD 10 code of each chronic physical health condition not falling into these categories:***

Chronic Health Condition	Impact	IDC 10 Code

Below are qualifying criteria for a chronic health condition for the program per He-M 523. Not all criteria are needed to qualify. ***Please check yes or no to the following statements.***
One or more of the chronic health condition(s) listed above:

YES	NO	
☐	☐	Will last or is expected to last for 12 months or longer.
☐	☐	Significantly affects the child/young adult's ability to function on a daily basis in the areas of emotional, social, or physical development.
☐	☐	Significantly affects the child/young adult's ability to function on a daily basis in his or her family, school, or community.
☐	☐	Requires more frequent and intensive medical care from primary care and specialty providers than is typically required for well child and acute illness visits.

Comment(s):

Certification

I certify that I furnished the above information and that the above information is true in whole.

(Signature of MD, DO, or APRN) *(Date)*

Print Name: Phone:

Address:

Please mail or fax to the NH Partners in Health regional office address/number below. Thank you.

FAMILIES COMMUNITIES PROFESSIONALS

Date Received:

(Office use only)

This form requires a release of information. Please see the attached release of information.