



**Connecticut Medical Home Initiative for  
Children and Youth with Special Health Care Needs\*  
FAVOR**

185 Silas Deane Highway  
Wethersfield CT 06109

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**PROGRAM APPLICATION**

Date:		Referred by: FAVOR		
<b>Child's Information</b>				
Last Name:		First Name:		
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Birth Date: / /	Social Security # - - To be eligible for Respite funds or ESF this is required		
Address:				
City:		State:	Zip Code:	
Preferred Language:				
<b>Race/Ethnicity</b>				
Hispanic <input type="checkbox"/> YES <input type="checkbox"/> NO				
Race <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Native American <input type="checkbox"/> Other (Specify)				
<b>Parent/Guardian Information</b>				
Name	Home phone #	Work phone #	Cell phone #	Best time to call
Mother:				
Father:				
Other:				
E-mail Address:				
<b>Does your child receive any of the following?</b>				
Social Security Income <input type="checkbox"/> YES <input type="checkbox"/> NO				
<input type="checkbox"/> Husky A <input type="checkbox"/> Husky B <input type="checkbox"/> Husky B+ <input type="checkbox"/> Husky C <input type="checkbox"/> Katie Beckett Waiver <input type="checkbox"/> Private Ins:				
Husky Health Plan ID#		Private Health Plan ID#		
Other Financial Support <input type="checkbox"/> YES <input type="checkbox"/> NO (if yes, please specify source*) _____				
(* i.e. Cystic Fibrosis Foundation, Pharmaceutical Subsidy, MDA, UCP, Lions' Club, Shriner's, etc.)				
<input type="checkbox"/> Is your child over the age of 18? <input type="checkbox"/> Is your Child a Full time student? <input type="checkbox"/> Is your child employed?				
<input type="checkbox"/> Does your child live out of the family home? <input type="checkbox"/> Does your child attend a Day Program? <input type="checkbox"/> Is your child on a wait list for a day program ?:				

\*The Connecticut Medical Home Initiative for Children and Youth with Special Health Care Needs is a program supported by the State of Connecticut Department of Public Health. Information is available on their website at [www.ct.gov/dph/medicalhome](http://www.ct.gov/dph/medicalhome)

<b>Mother's Information</b>			
Last Name:	Maiden Name:	First Name:	Birth Date: / /
Address:			Floor/Apartment:
City:	State:		Zip Code:
Social Security # - - Required for funding		Legal Guardian <input type="checkbox"/> Yes <input type="checkbox"/> No	
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed			
Employer:			
Employer's Address:			
Health Insurance:		Health Insurance ID #	
Health Insurance Phone #			
Health Insurance Mailing Address:			
City:	State:		Zip Code:
<b>Father's Information</b>			
Last Name:	First Name:		Birth Date: / /
Address:			Floor/Apartment:
City:	State:		Zip Code:
Social Security # - -		Legal Guardian <input type="checkbox"/> Yes <input type="checkbox"/> No	
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed			
Employer:			
Employer's Address:			
Health Insurance:		Health Insurance ID #	
Health Insurance Phone #			
Health Insurance Address:			
City:	State:		Zip Code:
<b>Contact information for legal guardian if other than the parent(s)</b>			
Last Name:	First Name:	Social Security # - -	
Address:			Floor/Apartment:
City:	State:	Zip Code:	Guardian Relationship:
<b>Family Income Information</b>			
Family Income	Amount	Annual Income	Amount
Child's Monthly SSI/SSDI		Father income OR SSI/SSDI	
Monthly Retirement		Mother income Or SSI/SSDI	
Monthly Alimony		Total Annual Income	
Monthly Child Support		Number of Children living in the house	
Monthly Temporary Family Assistance (TFA)		Number of Adults living in the house	
Other			
<b><u>PLEASE ATTACH A COPY OF YOUR MOST RECENT TAX RETURN OR FOUR CONSECUTIVE PAYSTUBS AS PROOF OF INCOME</u></b>			

## INFORMATION ON CHILD'S SPECIAL HEALTH CARE AND MEDICAL NEEDS

### Child's diagnosis(es)

<b>1. Primary Diagnosis</b>	
<b>2. Secondary Diagnosis</b>	
<b>3. Other Condition</b>	
<b>4. Other Condition</b>	

### Child's Primary Health Care Provider

<b>Provider's Name:</b>		<b>Phone #</b>
<b>Provider's Mailing Address:</b>		
<b>City:</b>	<b>State:</b>	<b>Zip Code:</b>

### Child's Dental Provider

<b>Provider's Name:</b>		<b>Phone #</b>
<b>Provider's Mailing Address:</b>		
<b>City:</b>	<b>State:</b>	<b>Zip Code:</b>

### Child's Specialty Care Provider(s)

Specialist's Name	Specialty	Address	Phone #

**2. Does your child have need of services that they are not currently receiving?**  Yes  No  
 (Example: Medication, Support Groups, Care Coordination, Special Education, Daycare or equipment etc.) If Yes, please describe:

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**3. If you have any matters or questions regarding your child that was not mentioned or covered by this form, please indicate below.**

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**4. Names of other children with special health care needs in the family currently in this program.**

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#### For Office Use Only

**Eligible for Extended Service Funds:**  YES  NO If NO, Explain reason

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