Connecticut Medical Home Initiative for
Children and Youth with Special Health Care Needs*
FAVOR
185 Silas Deane Highway
Wethersfield CT 06109
Tel: 860-436-6544 Toll Free: 855-436-6544
Fax: 860-563-3961 Email: CTMedicalHome@FAVOR-ct.org

PROGRAM APPLICATION

Date:	Referred by: FAVOR

Child's Information

Last Name:	First Name:	
Sex ☐ M ☐ F	Birth Date: / /	Social Security # - - To be eligible for Respite funds or ESF this is required
Address:		
City:	State:	Zip Code:
Preferred Language:		

Race/Ethnicity

Hispanic ☐ YES ☐ NO

Race ☐ White ☐ Black ☐ Asian/Pacific Islander ☐ Native American ☐ Other (Specify)

Parent/Guardian Information

Name	Home phone #	Work phone #	Cell phone #	Best time to call
Mother:				
Father:				
Other:				

If you prefer to be contacted via e-mail, please provide address:

Does your child receive any of the following?

Social Security Income ☐ YES ☐ NO

☐ Husky A ☐ Husky B ☐ Husky B+ ☐ Husky C ☐ Katie Beckett Waiver ☐ Private Ins:

Husky Health Plan ID# Private Health Plan ID#

Other Financial Support ☐ YES ☐ NO (if yes, please specify source*)_____

(* i.e. Cystic Fibrosis Foundation, Pharmaceutical Subsidy, MDA, UCP, Lions' Club, Shriner's, etc.)

☐ Is your child over the age of 18? ☐ Is your Child a Full time student? ☐ Is your child Employed ?

☐ Does your child live out of the famly home? ☐ Does your child attend a Day Program? ☐ 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.dph.state.ct.us.

Mother's Information

Last Name:	Maiden Name:	First Name:	Birth Date: / /
Address:			Floor/Apartment:
City:	State:		Zip Code:
Social Security # - - Required for funding		Legal Guardian ☐ Yes ☐ No	
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow			
Employer:			
Employer's Address:			
Health Insurance:		Health Insurance ID #	
Health Insurance Phone #			
Health Insurance Maling Address:			
City:	State:	Zip Code:	

Father's Information

Last Name:	First Name:	Birth Date: / /
Address:		Floor/Apartment:
City:	State:	Zip Code:
Social Security # - -	Legal Guardian ☐ Yes ☐ No	
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed		
Employer:		
Employer's Address:		
Health Insurance:	Health Insurance ID #	
Health Insurance Phone #		
Health Insurance Address:		
City:	State:	Zip Code:

Contact information for legal guardian if other than the parent(s)

Last Name:	First Name:		Social Security # - -
Address:			Floor/Apartment:
City:	State:	Zip Code:	Guardian Relationship:

Family Income Information

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			

PLEASE ATTACH A COPY OF YOUR MOST RECENT TAX RETURN OR FOUR CONSECUTIVE PAYSTUBS AS PROOF OF INCOME

INFORMATION ON CHILD's SPECIAL HEALTH CARE AND MEDICAL NEEDS

Child's diagnosis(es)

1. Primary Diagnosis	
2. Secondary Diagnosis	
3. Other Condition	
4. Other Condition	

Child's Primary Health Care Provider

Provider's Name:		Phone #
Provider's Mailing Address:		
City:	State:	Zip Code:

Child's Specialty Care Provider(s)

Specialist's Name	Speciality	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:

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

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

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