



**Regional Medical Home Support Center
For Children & Youth with Special Health Care Needs
At St. Mary's Children's Health Center**

56 Franklin St.
Waterbury, CT. 06706
Tel: 203-709-5716 Toll Free: 866-517-4388 Fax: 203-709-5153

REGISTRATION

Date _____

Child's Last Name _____ First Name _____ M ___ F ___

DOB _____ Social Security # _____ Preferred Language _____

Address _____

City _____ Zip Code _____ Referral Source _____

Contact Information

	Home Phone	Work Phone	Cell Phone Or Beeper	Best Time to Call
Mother:				
Father:				
Other Contact: <i>(please specify)</i>				

Race/Ethnicity: (Check One) <input type="checkbox"/> White (Non-Hispanic) <input type="checkbox"/> White (Hispanic) <input type="checkbox"/> Black (Non-Hispanic) <input type="checkbox"/> Black (Hispanic) <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Native American <input type="checkbox"/> Other (specify) _____

Mother's Last Name _____ First Name _____

Address _____

City _____ Zip Code _____ Employer _____

Employer's Address _____

Health Insurance _____ Insurance Phone _____

ID # _____ Group# _____

Insurance Address _____

Father's Last Name _____ First Name _____
 Address _____
 City _____ Zip Code _____ Employer _____
 Employer's Address _____
 Health Insurance _____ Insurance Phone _____
 ID # _____ Group# _____
 Insurance Address _____

Financial Information

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

Benefits and Special Assistance

Does your child receive any of the following?

SSI ___YES ___NO **DMR Waiver** ___YES ___NO **Other*** please specify _____
 (* For example, CF Foundation, Pharmaceutical Subsidy, MDA, UCP, Lions' Club, Shriner's, etc.)

Medicaid Health Insurance ___ YES ___NO

Husky Health Plan _____ **ID#** _____
 Please include copy of ID Card (front and back) Husky Type: A /B / B+ (please circle, if known)
Case Manager _____ **Tele#** _____

Family Income

Family Income:	Amount		Amount
Monthly SSI		Father's Monthly Income	
Monthly Retirement		Mother's Monthly Income	
Monthly Alimony		Total Monthly Income	
Monthly Child Support		Total Annual Income	
Monthly Temporary Family Assistance (TFA)		%FPL(office use only)	

Yearly Expenses

PLEASE ATTACH COPIES OF RECEIPTS OR PROOF OF EXPENSES

Yearly Expenses Not Covered by Insurance

Doctors_____	Prescriptions_____	Medical Insurance Premiums_____
Hospitals_____	Eyeglasses/Contacts_____	Childcare Costs_____
Dentist_____	Medical Equipment_____	Alimony Paid_____
Therapy_____	Co-Pays/Deductibles_____	Other_____
TOTAL Annual Expenses \$_____		

Household Size Number of children _____ Number of adults _____

For Office Use Only

Eligible for Extended Service Funds ___Yes ___No If NO, Explain reason_____

MEDICAL INFORMATION AND SPECIAL CARE NEEDS

Conditions/Diagnosis(es) and Complications*

Does your child have a physical (medical), behavioral, developmental or mental health condition that has lasted or is expected to last at least one year? Yes No (If yes, please continue)

1. Primary Diagnosis:	
2. Secondary Diagnosis:	
3. Complications:	
4. Complications:	
Allergies:	

(*Complications: For example, medical, emotional or social concerns related to the complex condition. For example, missed school or missed parent work days, depression, social or behavioral issues secondary to the complex condition)

Pediatric Primary Care Provider

Name: _____ Phone# _____

Address _____

How many times has your child seen the primary care provider in the last 12 months over and above well-child visits? _____

How many phone calls (approximately) have you made in the last 12 months to doctors, specialists, schools, agencies, to discuss your child's service needs? _____

Specialists/ER Usage/Hospitalizations

1. Does your child see any specialists (MD's, audiologists, feeding specialists, etc.)?

Yes No

Specialist's Name/Specialty

Address/Phone

_____	_____
_____	_____
_____	_____

How many times have specialists seen your child in the past 12 months? _____

2. Does your child need or get special therapy, such as PT, OT, Speech, Respiratory treatments such as postural drainage or regular nebulizer use, Counseling or other therapeutic interventions? (Please choose the answer that best describes the number of special services your child receives)

_____ One special therapy from list above _____ Two or more special therapies

3. Has your child been seen in an Emergency Department (ED), urgent care/walk-in center in the past 12 months? Yes No If yes, number of visits _____

Of these visits, how many times did the pediatric provider or specialist send your child? _____

4. Has your child been hospitalized for a medical/surgical problem in the past 12 months?

Yes No If yes, number of times hospitalized _____

Service and Support Needs

1. Are family members experiencing complications that may result from the stressors involved in being or caring for a child with complex care needs? (For example, teens demonstrating health risk behaviors, i.e. drugs, alcohol, smoking, dangerous driving habits, etc. OR adult family members demonstrating health risk behaviors, ie. Alcohol or drug dependency, depression, domestic violence) Yes No

2. Please describe any unmet needs for services and support you may have.

Thank you for completing this form. Please feel free to call with question, concerns or suggestions you may have. We look forward to hearing from you!