Special Medical Programs
Nutrition, Feeding and Swallowing Program

Nutrition, Feeding and Swallowing Application Packet

Thank you for your interest in the Nutrition Feeding and Swallowing Program! I am here to help you. If you have questions and/or want help completing the paperwork call or email me a time and way I can reach you.

Sarah Belhumeur
Intake and referral coordinator
Phone: (603) 296-9213 ; fax : (603) 296 0130
Email: sbelhumeur@amoskeaghealth.org

Nutrition, Feeding and Swallowing Paperwork:

1. **Special Medical Services application-** please complete and acknowledge with your signature.
2. **Screening Tool-** please check all appropriate boxes. Responses should best describe your child's *present* conditions
3. **Insurance Form-** complete the attached insurance release for which insurance company your child is covered under, and attach a copy of your child's insurance card, if possible.
4. **Release of Information form(s)-** please fill out one release per authorization (please complete one for your child's PCP, one for the birth hospital, and additional releases for specialists including GI and ENT).

You can get these to me by:

Email: scan and email the completed paperwork to sbelhumeur@amoskeaghealth.org. (Please do not send cell phone camera pictures of the completed paperwork).
Mail: mail to 145 Hollis Street Manchester, NH 03101 and put attention to Sarah at Nutrition, Feeding & Swallowing.
Fax: fax to my attention (Sarah at Nutrition, Feeding & Swallowing) to fax number 603 296 0130.

If you are having trouble getting the paperwork to me, please let me know and I will gladly work with you to complete/send the paperwork in a way that works best for your family.

I will contact you once your application has been processed and let you know of next steps.

Sarah

The Nutrition, Feeding and Swallowing Program
The Basics

What is the Nutrition, Feeding and Swallowing Program?

NFS Program Mission: To optimize the growth, health and well-being of your child by joining the expertise of our dieticians and feeding & swallowing providers with your expertise as parents and family, and others serving your child.

How does the program work?
Our program is a private program operated through two agencies (Amoskeag Health and SERESC), and focuses on YOUR goals for your child.

Our program is a consultative model for which your child is seen for an initial evaluation and follow-up visits. The success of our services come from you and our nutrition and/or feeding and swallowing providers having a close working partnership. As with any partnership, meeting your goals requires effective communication, commitment and follow through.

How is the program funded? Home/community-based visits are provided at no out of pocket costs to you. Our program relies upon insurance reimbursement and funding from Special Medical Services. If your child needs a swallow study, your feeding and swallowing provider will be covered by our program to attend. Your insurance company will be billed for the medical fees associated (please see the enclosed funding guide so you are fully informed).

BUREAU FOR FAMILY CENTERED SERVICES (BFCS)
APPLICATION FOR SERVICES

Please complete each section with the most current information*

If applicant is 18 or older, their signature is required on all forms. If applicant has a guardian, submit copy of legal documents.

Applicant Information

Applicant Name:_____ Date of Birth:_____Age: _____
Residence Address:_____
Mailing Address:_____
Primary Phone: _____Secondary Phone:_____
Primary Email:_____Secondary Email:_____
Sex assigned at birth: ☐ Male ☐ Female ☐ Choose not to disclose

Applicant's Race and Ethnicity

Are you Hispanic, Latino/a, or Spanish Origin?

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

What is your race?

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

Primary language spoken at home:_____ **Interpreter needed for**: ☐ Spoken ☐ Written ☐ ASL

US Citizen: ☐ Yes ☐ No **Legal Resident:** ☐ Yes ☐ No

Household Information—Those who reside in the same home with the applicant (check all that apply)

Applicant resides at home with their:

☐ Married parents ☐ Single parent ☐ Guardian or foster parents ☐ Unmarried parents/adults ☐ Grandparent(s)

☐ Applicant is an adult (18 or older) ☐ Applicant is married ☐ Applicant does not live with parents/guardians

Parent/Guardian name:_____ **Parent/Guardian name:**_____

Siblings in home under the age of 18

Number of siblings under the age of 18 residing in home _____ Number of siblings enrolled with BFCS _____

Please lists siblings enrolled in BFCS programs. Please check if enrolled with Special Medical Services (SMS) or Partners in Health (PIH)

Name: _____Age: _____☐ SMS ☐ PIH Name: _____Age: ____☐ SMS ☐PIH

Name: _____Age: _____☐ SMS ☐ PIH Name: _____Age: ____☐ SMS ☐PIH

Please attach list with any additional names.

Other services applicant is CURRENTLY enrolled and ACTIVELY receiving

☐ Social Security Payments ☐ Special Education Services ☐ Partners in Health ☐ Special Medical Services

☐ Area Agency ☐ Early Supports and Services ☐ WIC

Health Insurance information

Medicaid: ☐ Yes ☐ No ☐ Pending Medicaid Number: _____

Managed Care Organization (MCO): _____ MCO Number_____

Other Insurance Name: _____ Policy Number:_____Group ID:_____

Subscriber:_____Subscriber's Date of Birth:_____Relation:_____

BFCS services being requested

☐ Health Care Coordination ☐ Complex Care Network ☐ Partners in Health
☐ Child Development Evaluation ☐ Nutrition, Feeding and Swallowing
☐ Other (explain) _____

Current Diagnoses

Diagnoses:_____
_____

Referred by:

☐ Primary care physician (MD/FP/NP)
☐ Other type of health care provider
☐ Out of state specialty program
☐ Medical specialist
☐ School district/ School nurse
☐ Early Supports and Services
☐ Area Agency
☐ Nutrition program
☐ Home/public health
☐ Hospital
☐ Partners in Health
☐ Parent
☐ Friend
☐ VNA
☐ Special Medical Services
☐ NH Family Voices
☐ Other _____

Applicant's providers and services

PROVIDER/SPECIALIST	PROVIDER NAME	OFFICE/ADDRESS	TELEPHONE
Primary care provider			
Specialist			
Specialist			
Specialist			
Dentist			
Early Supports and Services			
Special educator/teacher			
Speech therapist			
Physical therapist			
Occupational therapist			
School nurse			
Area Agency			
Home care services			
Equipment vendors			

Thank you for completing the BFCS application.

_____ _____ _____

Print name Parent/guardian/self (18 or older) **Signature** Parent/guardian/self (18 or older) **Date Signed**

The signature above shall attest that all information provided in the 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 BFCS receives its funds from state and federal sources. I also realize the BFCS may use other state data or resources to verify the information provided in this application.

Return signed application to: BFCS, 129 Pleasant St– Thayer, Concord NH 03301 or BFCS@dhhs.nh.gov

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.

AMOSKEAG HEALTH

SERESC

Special Medical Programs

Nutrition, Feeding and Swallowing Program

Purpose: This tool was developed to support fellow professionals to identify children birth to 21, whose medical, social, developmental, behavioral, and environmental conditions place the child at risk for nutrition, feeding and swallowing concerns. Please complete both sides.

Child's Name: _____ **Child's DOB:** _____

Check all that apply:

- ☐ Prenatal history of IUGR (Intrauterine growth restriction)
- ☐ Failure to Thrive
- ☐ Extreme prematurity: with lung disease, slow growth
- ☐ Prenatal exposure to drugs, alcohol or infection
- ☐ Brain injury: Asphyxia, bleed, periventricular leukomalacia, Traumatic brain injury
- ☐ Neuromotor conditions: Cerebral palsy; mitochondrial disease; Muscular dystrophies such as myotonic muscular dystrophy, leukodystrophies
- ☐ Anatomical differences: Cleft lip/palate, laryngeal clefts, Pierre Robin sequence, tongue and/or lip tie, tracheoesophageal atresias, enlarged tongue,
- ☐ Respiratory conditions: BPD or unexplained asthma, frequent respiratory illnesses such as pneumonia, bronchitis, year round cold symptoms, un-resolving ear infections, extreme prematurity
- ☐ Genetic differences: Syndromes (Down, Velocardiofacial /DiGeorge, Williams, Prader-Willi, Russell-Silver, Cornelia de Lange) Cystic fibrosis , etc.
- ☐ Cardiac conditions: Congenital heart defects impacting weight gain and growth
- ☐ Digestion conditions: Reflux, Esophagitis, delayed gastric emptying, slow GI motility, malabsorption, constipation
- ☐ Significant food allergies and/or intolerances restricting child's nutritional intake and growth
- ☐ Other: _____

If you have checked any one of the boxes above an NFS referral is indicated. If you would like to make a referral, please complete the application for Special Medical Services, or if you would like more information regarding the referral process, contact the NFS Program Office: 603-296-9213.

A Collaborative Program between Amoskeag Health, SERESC and NH DHHS, Bureau of Special Medical Services.
Amoskeag Office: 1245 Elm Street, Manchester, NH 03101.
SERESC: 165 S. River Road, Suite F, Bedford, NH 03110.
Mailing Address: 145 Hollis Street, Manchester, NH 03101

AMOSKEAG HEALTH
SPECIAL MEDICAL PROGRAMS

SERESC

Special Medical Programs

Nutrition, Feeding and Swallowing Program

The following represent nutrition, feeding and swallowing indicators parents may report or that you may observe.

Check all that apply:

- ☐ Child is not growing as expected, or has had abnormal weight loss
- ☐ Child's wt. gain is higher than expected
- ☐ Difficulties with breast/bottle feeding and/or transitioning from breast/bottle feeding to other means of intake
- ☐ Difficulties with advancing textures, i.e. purees to table foods
- ☐ Eating and drinking-related color changes, breathing difficulties, gagging, coughing, choking, congestion, wet voice quality, food/drink coming out of nose.
- ☐ Requires very lengthy meal times (longer than 30 minutes)
- ☐ Very low volume intake of food/drink
- ☐ Extremely limited food selection/food aversion
- ☐ Suspected nutrient inadequacies
- ☐ Frequent spitting up and/or vomiting with pain/discomfort
- ☐ Tube feeding for nutrition and/or hydration
- ☐ Child demonstrates atypical meal time behaviors

If you have checked any one of the boxes above an NFS referral is indicated. If you would like to make a referral, please complete the application for Special Medical Services, or if you would like more information regarding the referral process, contact the NFS Program Office: 603-296-9213.

A Collaborative Program between Amoskeag Health, SERESC and NH DHHS, Bureau of Special Medical Services.
Amoskeag Office: 1245 Elm Street, Manchester, NH 03101.
SERESC: 165 S. River Road, Suite F, Bedford, NH 03110.
Mailing Address: 145 Hollis Street, Manchester, NH 03101

AMOSKEAG HEALTH

SERESC

Special Medical Programs
Nutrition, Feeding and Swallowing Program

Authorization for Disclosure of Protected Health Information

Patient's Name: _____ Date of Birth:

I authorize the following agency/individual to release my protected health information:

☑FROM ☑TO	☑FROM ☑TO
Amoskeag Health 145 Hollis Street Manchester, NH 03101 Phone (603) 296-9213 Fax (603) 296-0130	SERESC 165 S. River Road Bedford, NH 03110 Phone (603)-206-6838 Fax (603)-206-2588	Agency/Individual: _____ Address: _____ City _____ ST _____ Zip _____ Phone _____ Fax _____

INFORMATION TO BE RELEASED:

☐Consult ☐Discharge Summary ☐Education (☐PT/OT/SLP,☐IEP,☐Evaluation/Progress notes) ☐ Other☐NFS☐

SPECIFIC MEDICAL DOCUMENTS: ☐ Physicals ☐Lab Reports ☐Office Notes ☐Growth Charts ☐ X-Ray
☐Other_____

☐ ENTIRE RECORD (First copy free of charge, subsequent copy $0.50 per page)

☐ VERBAL EXCHANGE ☐Medical records not created by Amoskeag Health (there is a fee for this option, $0.50 per page, $5 min)

SPECIFIC SENSITIVE DOCUMENTS **WILL NOT BE** included unless specifically authorized for release by your initials:
☐Mental Health /Behavioral Health, ☐ Alcoholism/ Drug Abuse, ☐HIV/AIDS, ☐STD's

☐SPECIFIC DATES: From: _____ To: _____

For the following purpose(s):

☐Neuromotor Clinic ☐Care Coordination ☐Child Development Clinic ☐Complex Care ☐ Nutrition, Feeding, Swallowing

Disclosure of Direct or Indirect Payment received by any person or organization authorized to use or disclose my health information - I understand that Amoskeag Health, Special Medical Programs, will NOT receive any direct or indirect payment in connection with the use or disclosure of my health information. This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Your rights with respect to this authorization:

Right to Inspect or Copy the Health Information to Be Used or Disclosed: I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the Medical Records Department or Privacy Officer.

Right to Receive Copy of This Authorization: I understand that I must be provided a copy of this form.

Right to Refuse to Sign This Authorization: I understand that I am under no obligation to sign this form and that the person(s) and/or organization listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to not sign this authorization.

Right to Withdraw This Authorization: I understand that written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the Medical Records Supervisor. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and/or organization listed above have already made in reference to this authorization.

NOTE: Protected health information used or disclosed pursuant to this authorization may or may not be subject to re-disclosure by recipient.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes. I hereby authorize release of my patient information stated above.

Expiration Date: This authorization is valid one year from the date signed below.

Signature of Patient, Parent, or Guardian: _____ Date: _____

Printed Name of Patient, Parent, or Guardian: _____

Signature of interpreter(if applicable):_____

Implemented: 11/1/17 Revised: 09/12/19

Special Medical Programs
Nutrition, Feeding and Swallowing Program

INSURANCE INFORMATION SHEET

REFERRING PHYSICIAN: _____

***Child's Name**_____Birthdate_____Sex: M☐ F☐
Last First MI

***Primary Insurance Co**._____ Effective Date_____

***Card and/or ID #** _____

***Subscriber's Name:** _____

***Relationship to Patient:** _____

***Subscriber's Date of Birth:**

_____

***Secondary Insurance Co. (If applicable):** _____

***Card and/or ID#** _____

_____

DISCLOSURE STATEMENT

I authorize the Nutrition, Feeding, and Swallowing Program at Amoskeag Health and/or SERESC to submit claims to my insurance carrier and to release any medical information necessary to process all claims. I also authorize payment of medical benefits to the aforementioned for all services provided until further notified for this account.

_____ _____
Parent/Guardian (Print Name) Date

_____ _____
Parent/Guardian (Signature) Date

**A Collaborative Program between Amoskeag Health,
SERESC and NH DHHS, Bureau of Special Medical Services.
Amoskeag Office: 1245 Elm Street, Manchester, NH 03101.
SERESC: 165 S. River Road, Suite F, Bedford, NH 03110.
Mailing Address: 145 Hollis Street, Manchester, NH 03101**

Special Medical Programs
Nutrition, Feeding and Swallowing Program

Notice of Privacy Practices

Uses and Disclosures of Protected Health Information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our Duty to Safeguard Your Protected Health Information
Individually identifiable health information about your past, present, or future health or condition, the provision of health care to you, or payment for the health care is considered "Protected Health Information" (PHI). We are required to extend certain protections to your PHI, and to give you this notice about our privacy practices that explains how, when, and why we may use or disclose your PHI. We will use or disclose only the minimum necessary PHI, except where we are legally required to do otherwise. We are required to follow the privacy practices described in this Notice, though we reserve the right to change our privacy practices and the terms of this Notice at any time. If we do so, we will post a new notice in our Business Office. You may request a copy of the new Notice from the Business Office.

How We May Use or Disclose Your Protected Health Information
Special Medical Programs uses PHI about you for treatment, payment and health care operations.

Treatment – Special Medical Programs may disclose your PHI to doctors, nurses, laboratories and other health care personnel involved in providing your health care. For example, if you are seen in the Emergency Department at the hospital, we may disclose your PHI to healthcare providers treating you there.

Payment - Special Medical Programs may disclose your PHI in order to bill and collect payment for your health care services. For example, we may disclose your PHI to your insurance company or another 3rd party entity or individual responsible for the payment of your care.

Health Care Operations – We may use your health information and disclose it outside Special Medical Programs for our health care operations. For example, an audit of the facility might be conducted for cost management review or for a review of quality of care.

Contacting You- We may use and disclose health information to reach you about appointments and other matters. We may contact you by FAX, mail, telephone, text message, or e-mail. We may leave FAX, emails, voice or text messages at the telephone number you give. We may send protected reports via FAX, email (or mail) and respond to your e-mail.

Other Instances When We Might Reveal Health Information

When Required by Law – We may disclose PHI when a law requires that we report information about suspected abuse, neglect or domestic violence, or relating to suspected criminal activity, or in response to a court order. We must also disclose PHI to authorities that monitor compliance with these privacy requirements. A civil or criminal proceeding involving you may also require us to disclose PHI about you by a court or administrative order. We may also be required to report or disclose private health information to a Workers Compensation claims carrier.

For Public Health Activities – We may disclose PHI when we are required to collect information about disease or injury, or to report vital statistics to public health authorities. We may also be required to disclose PHI for notification of sexually transmitted diseases or reactions to drugs or other devices associated with your treatment.

For Health Oversight Activities – We may disclose PHI to oversight agencies responsible for health center licensure or accreditation as well as entities charged with oversight of the health system, inspection, compliance with state and federal laws or the investigation of unusual incidents or accidents.

Relating to Decedents – We may disclose PHI relating to an individual's death to coroners, medical examiners or funeral directors and to organ procurement organizations relating to organ, eye or tissue donations or transplants.

For Research Purposes – In certain circumstances, and under the supervision of an institutional review board, we may include your PHI in a data pool to assist medical or psychiatric research. This pool will not contain information that individually identifies you. This data pool is a source of information that we use to evaluate the services that Special Medical Programs provides to the community.

To Avert Threat to Health or Safety – In order to avoid a serious threat to health or safety, we may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm, including situations regarding a crime victim, death from criminal conduct or other criminal conduct relating to you.

For Specific Government Functions – In certain situations, we may disclose PHI: of military personnel or veterans; to correctional facilities; to government programs relating to eligibility and enrollment; and for national security reasons.

Your Rights

You have the right to request restriction on uses and disclosures of your information - You have the right to ask that we limit how we use or disclose your PHI. To request a restriction, you must make the request in writing to the Privacy Officer of this health center. The request MUST state what information you wish restricted and who you want this information restricted from. Although we will work with you to protect your information we cannot accommodate all requests and are not legally bound to accept all requests, where disclosure may be legally required, and therefore reserve the right to reject a request for a restriction. Unless we have specifically agreed to your request we will not be able to accommodate it. If we do agree to the restriction we will be bound by our agreement except in the case of a legal requirement, emergencies or if the information is otherwise necessary to treat you.

You have a right to inspect and obtain a copy of your health records - Although your health record is the physical property of this health center, the information contained in it belongs to you. Unless your access is restricted for clear and documented treatment reasons, you have the right to see your PHI. Your request must be made in writing. We will respond to your request within 30 days. If we deny your access, we will give you written reasons for the denial and explain any right to have the denial reviewed. There may be a fee for copies and we are permitted to withhold certain information from your records, such as psychotherapy notes.

You have a right to request an amendment to your health record – If you believe that there is a mistake or missing information in our record of your PHI, you may request, in writing, that we correct or add to the record. We will respond within 60 days of receiving your request. We may deny the request, if we determine that the PHI is: (i) correct and complete; (ii) not created by us and/or not part of our records, or, (iii) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your PHI. If we approve the request for amendment, we will change the PHI and so inform you.

You have a right to obtain an accounting of disclosures of your health information – You have a right to receive a listing as to what, when, to whom, and for what purpose your PHI was released for purposes other than treatment, payment, and healthcare operations. This list will not include disclosures made for national security purposes, to law enforcement officials or correctional facilities or those disclosures made before April 2003. We will respond to your written request within 60 days.

You have a right to receive confidential communications – You have a right to request, in writing, that we send you information at an alternative address or by alternative means and may choose how we contact you. We will agree to your request so long as we are reasonably able to do so.

You have a right to a paper copy of this notice.

You have a right to provide an authorization for the use of your health information not otherwise described in this notice - Any authorization you grant to us to use your health information may be withdrawn at any time so long as notice is given in writing. Further details of your rights in regard to an authorization will be detailed in the authorization form itself.

For More Information or to Report a Problem

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice.

For Special Medical Programs:
Kris McCracken
Privacy Officer
Amoskeag Health
145 Hollis Street
Manchester, NH 03101
(603) 626-9500

For Feeding and Swallowing Services:
Judith H. Mikami or Alicia Garcia
Privacy Officers
SERESC
165 S. River Road Suite F
Bedford, NH 03110
(603) 206-6838

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed above. You also may send a written complaint to the US Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request. There will be no retaliation for filing a complaint.

We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area and in each examination room. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed above.

Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice.

Acknowledgment of receipt of Notice of Privacy Practices: Please sign and print your name and date below to acknowledge that you have received both pages of this Notice of Privacy Practices. ☐ Copy Provided ☐ Copy Denied

Signature: _____ Printed Name: _____
(Patient/Parent/Guardian) (Patient/Parent/Guardian)

Patient's Name: _____ Date signed: _____

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.
This notice consists of two (2) total pages and must be considered in its entirety.