



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

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

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