THIS SIDE IS FOR THE PERSON APPLYING FOR FANF (other side is for the healthcare provider).

Determination of Incapacity for FANF Financial Assistance

Name | **Street address**

Case #, RID #, or MID #, if known | **City/town** | **State** | **Zip**

Date of FANF application | **Date of birth** | **Phone**

Authorization for Release of Protected Health Information

Purpose of disclosure: This authorization form is to let (authorize) your healthcare provider give (release or disclose) some protected health information to DHHS for the Financial Assistance to Needy Families (FANF) program. DHHS uses this information to learn if you have a health problem (incapacity) that makes it harder to care for your child or children.

If you sign this form, you let your healthcare provider give DHHS (or a company DHHS works with) the information asked for on the other side of this form. You do not have to sign this form. But, if you do not sign this form, your healthcare provider cannot share your health information and you may not be able to get help from FANF.

Please check all that apply to you:

☐ I let the healthcare provider I list here share protected health information about how my health problem makes it hard to care for my child or children. (See the other side for the kinds of providers who may fill out this form.)

Healthcare provider name: _____

Company: _____ Phone: _____

Address: _____

☐ I let my healthcare provider share the information listed on the back of this form about my health problem (incapacity): my diagnosis, whether or not the problem makes it hard to care for my child or children, when it started, how long it may last, and the medical treatment I am getting or have been asked to get.

☐ Some kinds of health information are extra protected. If you want to share this kind of information, check this box and write your initials on the line or lines you want to share.

_____ I want to share information about my treatment for mental health.

_____ I want to share information about my treatment for substance use disorder. (Federal law/42 CFR part 2 forbids unauthorized disclosure of these records.)

_____ I want to share information about my treatment for HIV or AIDS.

☐ I let my protected healthcare information listed on the other side of this form be given to: Family Services Specialist within DHHS, via DHHS's Centralized Scanning Unit, PO Box 181, Concord, NH 03301.

Federal privacy law says that a form like this one must say that if you sign it and your health information gets shared (disclosed), you should know the information may be shared again (re-disclosed). However, DHHS will not share your health information.

What if you change your mind? After you sign this form, you can stop your permission by writing a note to DHHS. But, DHHS may not get the note until after your healthcare provider already shared the information.

When does my authorization end? It will end one year from the date you sign this form (or earlier, if you ask).

Please sign your name and today's date to let your healthcare provider share the health information asked for on the other side of this form.

Signature of FANF applicant or duly authorized legal representative | **Date**

THIS SIDE IS FOR THE HEALTHCARE PROVIDER (other side is for the person applying for FANF).

Dear Healthcare Provider: You are receiving this form because you are a healthcare provider for:

Please print patient name here: _____

This individual applied for help from the Financial Assistance to Needy Families (FANF) program. To qualify:

- the individual must be physically or mentally incapacitated to the extent that his or her ability to support or care for his or her children is substantially reduced; **and either**
  - the incapacity is expected to last for 30 continuous days from the FANF application date identified on the other side of this sheet; **or**
  - the incapacity lasted for 30 continuous days in the 90-day period prior to the FANF application date identified on the back of this sheet.

The individual's signature on the other side of the form serves as an authorization to release the protected health information requested below.

Only the following currently licensed healthcare providers are authorized to complete and sign this form—
Please check the corresponding box to indicate your profession:

☐ Physician ☐ Physician Assistant ☐ APRN
☐ Psychologist (board certified) ☐ Clinical Mental Health Counselor ☐ Pastoral Psychotherapist
☐ Independent Clinical Social Worker ☐ Alcohol and Drug Counselor (MLADC only) ☐ Marriage & Family Therapist

Please complete the following statements:

I certify that the identified individual is incapacitated to the extent that his or her ability to support or care for his or her child(ren) is substantially reduced:

☐ Yes ☐ No

The incapacity began _____/_____/_____ **and**

The incapacity is expected to last until _____/____/____ **or** the incapacity ended _____/____/_____

The diagnosis for this incapacity is _____

My diagnosis is based on: ☐ Examination _____/_____/_____
☐ Medical records _____/_____/_____
☐ Other (specify) _____ _____/_____/_____

Medical treatment I am currently giving this individual: _____

_____

Medical treatment I recommend for this individual: _____

_____

Childcare: DHHS may be able to help a two-parent family obtain childcare if certain criteria are met.
Please check the following box if applicable to this individual:
☐ Individual is unable to care for or supervise his or her child(ren) due to the disability listed above.

_____ _____
Authorized healthcare provider signature Date

_____ _____
Authorized healthcare provider printed name Phone

_____ _____
Street address City/Town State Zip

Healthcare provider—please mail form to: Centralized Scanning Unit, PO Box 181, Concord, NH 03301.

Payment of any separate charge for completing this form is the responsibility of the patient.