

**VENTILATOR ASSISTED CHILDREN'S HOME PROGRAM
PROGRAM APPLICATION**

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***THIS APPLICATION MUST BE ACCOMPANIED BY MEDICAL AND DEVELOPMENTAL
SUMMARIES.**

GENERAL INFORMATION:

Child's Name: _____ Social Security: _____

Parents/Guardians: (Mother) _____ (Father) _____

Address: _____

_____ County: _____

Phone Number: _____ Email: _____

Date of Birth: _____ Sex: Male Female

Race (check one):

- White
- Black
- American Indian or Alaskan Native
- Asian/Pacific Islander
- Multi-racial
- Other

Origin (check one):

- Hispanic
 - Not of Hispanic Origin
- Resident of Pennsylvania
 Yes No
- Resident/Permanent Citizen of USA
 Yes No

Primary Diagnosis:

Secondary Diagnosis:

Child' Current Residence:

- Home Date discharged to home: _____
- Hospital Name of Hospital: _____
Date Admitted: _____
Expected date of discharge: _____

Other (specify): _____

Hospital Discharge Team (Name and phone number):

Physician: _____

Social Worker: _____

Discharge Coordinator: _____

MEDICAL STATUS:

Date mechanical ventilation initiated: _____

Type of respiratory support (check all that apply):

- Tracheostomy
- Positive pressure ventilation
- CPAP
- Negative pressure
- Facial mask ventilation
- Supplemental oxygen

Circumstances necessitating ventilator support: _____

Prognosis for weaning: _____

Size and style of tracheostomy tube: _____

Type of ventilator: _____

Settings: Rate: _____
 PIP: _____
 PEEP/CPAP: _____
 Tidal volume: _____
 FiO2: _____
 Hours of ventilator: _____

Current diet: _____

Frequency of feedings: _____

Route of feedings (check all that apply):

- PO
- GT
- NG
- NJ
- Other (specify): _____

Weight: _____ Height: _____ Head circumference: _____

Current Medications:

Current Developmental Level (strengths, weaknesses, current therapy program):

HOME ENVIRONMENT:

- Type of House:
- Apartment
- Single House
- Row house
- Other (specify):

Patient's bedroom:

- Own
- Other (specify): _____

Family Members

NAME	DOB	RELATIONSHIP TO CHILD	CAREGIVER FOR VENT CHILD? YES OR NO

Describe family's available support system(s):

Mother employed: No Yes (specify employer): _____

Father employed: No Yes (specify employer): _____

Annual income:

- Under \$10,000 \$40,000-\$50,000 \$80,000-\$90,000
- \$10,000-\$20,000 \$50,000-\$60,000 >\$90,000
- \$20,000-\$30,000 \$60,000-\$70,000
- \$30,000-\$40,000 \$70,000-\$80,000

Type of Insurance (check all that apply):

- Private Insurance (specify): _____
- BC/BS (specify): _____
- MA HMO (specify): _____
- MA Access (specify #): _____
- CHAMPUS: _____
- Michael Dallas Waiver: _____
- Other (specify): _____

Identify Insurance Contact Person(s) and telephone number: _____

Home Care Service Providers:

NAME	ADDRESS	TELEPHONE
PEDIATRICIAN		
PULMONOLOGIST		
NURSING AGENCY		
EQUIP/SUPPLY VENDOR		
REHAB SERVICES		
COMMUNITY/SOCIAL AGENCY		
OTHER (specify):		

Planned Educational Home Care Program:

Type of Program (check all that apply):

- Early Intervention
- Primary/HS
- Vocational
- College
- Other (specify): _____

Place of Services:

- Home-based
- Center-based
- Combination

Name of educational provider or school: _____

Comments:

Anticipated or actual discharge or home care problems (i.e. nursing; loss from work; sibling issues; lack of supports, sibling issues; housing, problems with education system; financial)

Application completed by:

NAME	TITLE	DATE