Children and Youth with Special Health Care Needs (CYSHCN) Nutrition Network Training
Application for Virtual Training to be held January 19-20, 2023 – Application Due 10/28/22

Name:_____ Position: _____

Highest Degree/Major: _____

Registered Dietitian Nutritionist: Yes/No Certified Dietitian/Nutritionist: Yes/No Years in pediatric nutrition:_____

Employer:_____ Work Phone: _____

Work Address: _____

City: _____ State:_____ Zip :_____

Work email: _____ Personal email*: _____
(*Personal email required to prevent loss of contact in case of change in workplace)

Counties that you serve: _____

1. Are you fluent in any languages other than English? Yes/No Which ones? _____

2. Place a check by all of the programs or organizations that financially support your position.

___Health Department	__ MSS Program	__ Head Start/ECEAP/Early Head Start
__ Home Health	__ Community Clinic	__ CYSHCN Program
__ Long-term Care	__ Migrant Health	__ WIC Program
__ Hospital	__ Indian Health Services	__ Private Practice
__ Managed Care Plan	__ Military Hospital/Clinic	__ Other: _____
	__ School District	__ Other: _____

3. **Circle** all of the programs or organizations in the list **above** with whom you currently interact in your job.

4. Please mark the population groups to whom you provide direct nutrition services in your current position:

__ Birth to 3 years	__ Adults with developmental disabilities	__ Adults
__ 3 to 6 years	__ Children with special health care needs	__ Pregnant/lactating individuals
__ 6 to 18 years	__ Other _____	

5. Approximately how many CYSHCN do you see for nutrition services in a typical month? _____

6. Please describe the mechanism and sources you have for receiving referrals for nutrition services for CYSHCN in your community.

_____

_____

_____

7. In your position, are you able to accept new nutrition referrals for CYSHCN?

__ Yes __ No __ Not Sure

If yes, how many CYSHCN could you see per month? _____

(***Application continues on second page***)

8. Would you need new financial support to provide nutrition services for additional CYSHCN?

__ Yes __ No __ Not Sure

If yes, where do you anticipate these funds coming from? _____

9. Have you or your agency ever been reimbursed for nutrition services you provided in your current position by:

Medicaid	__ Yes	__ No	__ Not sure
Managed Care Plan	__ Yes	__ No	__ Not sure
Private Insurance	__ Yes	__ No	__ Not sure
Children & Youth with Special Health Care Needs Program	__ Yes	__ No	__ Not sure
Private Payment	__ Yes	__ No	__ Not sure

10. Please list your objectives for attending this specialized pediatric nutrition training for CYSHCN.

_____

_____

11. How will you apply the information/skills you gain from this training in your work setting and community?

_____

_____

_____

_____

12. Will you have the support of your administrators to attend this virtual training? __ Yes __ No __ Not sure
Comments:

13. Do you anticipate having the support of your administrators to attend one annual CYSHCN Nutrition Network meeting each year after you complete the training?

__ Yes __ No __ Not Sure

15. Please describe any other comments, suggestions, or concerns you have regarding this training.

_____

_____

_____

Return completed application by Friday, October 28, 2022 to:

Mari Mazon, MS, RDN, CD
CHDD, Box 357920 University of Washington/Seattle, WA 98195-7920
Phone: (206) 598-3025 FAX: (206) 598-7815 email: lilmaro@uw.edu

You may mail (application must be received by October 28, 2022), scan and email, or fax the application to Mari Mazon.