

**Children and Youth with Special Health Care Needs (CYSHCN) Nutrition Network Training**  
***Application for Virtual Training to be held February 6-7, 2025 – Application Due 10/11/24***

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?                      Which ones? \_\_\_\_\_

2. Please select all of the programs or organizations that financially support your position:

3. Please select all the programs or organizations in the list with whom you most closely interact in your current job:

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

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Birth to 3 years | <input type="checkbox"/> Adults with developmental disabilities  | <input type="checkbox"/> Adults                         |
| <input type="checkbox"/> 3 to 6 years     | <input type="checkbox"/> Children with special health care needs | <input type="checkbox"/> Pregnant/lactating individuals |
| <input type="checkbox"/> 6 to 18 years    | <input type="checkbox"/> 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	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Managed Care Plan	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Private Insurance	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Children & Youth with Special Health Care Needs Program	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Private Payment	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> 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 October 11, 2024 to:**

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

You may mail (application must be received by October 11, 2024), email, or fax the application to Mari Mazon.