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| **Client information** | | | | | | | | |
| **First name:**  Click or tap here to enter text. | | **Last name:**  Click or tap here to enter text. | | | | | **Date of birth:**  Click or tap here to enter text. | |
| Preferred name:  Click or tap here to enter text. | | Pronouns:  Click or tap here to enter text. | | | | Email address:  Click or tap here to enter text. | | |
| Address:  Click or tap here to enter text. | | | **City:**  Click or tap here to enter text. | | | | | **ZIP:**  Click or tap here to enter text. |
| Phone #1:  Click or tap here to enter text. | Phone #2:  Click or tap here to enter text. | | | **Language:**  **Cantonese**  **English**  **Russian**  **Spanish**  **Vietnamese**  **Other:** | | | | |
| **Race (check all that apply):**  **African American or Black**  **American Indian or Alaska Native**  **Asian**  **Native Hawaiian or Other Pacific Islander**  **White**  **Declined to Answer  Unknown  Other** | | | | | **Ethnicity:**  **Hispanic or Latino  Not Hispanic or Latino**  **Declined to Answer  Unknown** | | | |

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| **Insurance application information** | | | | | | | Women’s Infants and Children (WIC) program | | |
| **Current insurance:** | | **CAWEM  CAWEX  OHP  Private  Other State’s Medicaid  Other  None** | | | | Current insurance end date: Click or tap here to enter text. | Current WIC client: | | Yes  No  Scheduled |
| App. submitted date: | | | | Click or tap here to enter text. | Reapply date: | Click or tap here to enter text. | Family number: | | Click or tap here to enter text. |
| **Approval:** | **OHP approved  CAWEX approved  QHP approved** | | | | | | Family income: | | Click or tap here to enter text. |
| If OHP, which CCO: | | | Click or tap here to enter text. | | | | Notes: | Click or tap here to enter text. | |

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| **Client screening** | | | | | | | | | | |
| **LMP date:** | Click or tap here to enter text. | | EDD: | Click or tap here to enter text. | | | Client already has confirmation of pregnancy?  Yes  No | | | |
| Pregnancy history | | Client needs identified | | | | | | | | |
| Gravida: | Choose an item. | Tobacco use: | | | Yes  No | Domestic violence: | | Yes  No | Food insecurity: | Yes  No |
| Para: | Choose an item. | Alcohol use: | | | Yes  No | Prenatal vitamins: | | Yes  No | Housing insecurity: | Yes  No |
| Abortion: | Choose an item. | Drug use: | | | Yes  No | Plan to breastfeed: | | Yes  No | Transport. needs: | Yes  No |
| Living child: | Choose an item. | PMD: | | | Yes  No |  | | Yes  No |  | Yes  No |

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| **Services delivered by OMC site** | | | | | **Date of services:** | Click or tap here to enter text. |
| **Prenatal care** | **Initial prenatal needs screening** | | **Prenatal care (PNC) provider selected** | | | |
| **PNC appointment scheduled** | | **PNC appointment confirmed by OMC site** | | | |
| **Insurance** | **OHP application assistance** | | **OHP community partner referral** | | | |
| **Health & social supports** | **Pregnancy test** | |  | | | |
| **WIC:**  **Certification  Referral** | **Primary care provider:**  **Education  Referral** | | **Smoking cessation:**  **Education  Referral** | | |
| **Home visiting:**  **Education  Referral** | **Dental:**  **Education  Referral** | | **Transportation assistance:**  **Education  Referral** | | |
| **Childbirth class:**  **Education  Referral** | **Behavioral health:**  **Education  Referral** | | **Other community referrals** | | |

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| **Prenatal care (PNC) information** | | | | | | | | | |
| **Has client started PNC prior to OMC contact?** | | **Yes (indicate date below):** | | | | **OR** | **No (indicate the date PNC received after OMC contact below):** | | |
| Click or tap here to enter text. | | | | Click or tap here to enter text. | | |
| Name of prenatal care provider or clinic: | | | | Click or tap here to enter text. | | | | | |
| **If no date above, select reason:** | **Declined**  **Lost to f/u** | | **Option undecided**  **Will make own appt** | | **Pending OHP appr.**  **TAB (abortion)** | | | **SAB (miscarriage)**  **Transferred care** | **Gave birth**  **Pending clinic response** |

Notes: Click or tap here to enter text.

Form Complete?

🞏 Yes 🞏 No

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| Client information | | | | | | | | |
| First name:  Click or tap here to enter text. | | Last name:  Click or tap here to enter text. | | | | | Date of birth:  Click or tap here to enter text. | |
| Preferred name:  Click or tap here to enter text. | | Pronouns:  Click or tap here to enter text. | | | Email address:  Click or tap here to enter text. | | | |
| Address:  Click or tap here to enter text. | | | City:  Click or tap here to enter text. | | | | | ZIP:  Click or tap here to enter text. |
| Phone #1:  Click or tap here to enter text. | Phone #2:  Click or tap here to enter text. | | | Language:  Cantonese  English  Russian  Spanish  Vietnamese  Other: | | | | |
| Race (check all that apply):  African American or Black  American Indian or Alaska Native  Asian  Native Hawaiian or Other Pacific Islander  White  Declined to Answer  Unknown  Other | | | | | | Ethnicity:  Hispanic or Latino  Not Hispanic or Latino  Declined to Answer  Unknown | | |

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| Insurance application information | | | | | | | Women’s Infants and Children (WIC) program | | |
| Current insurance (select one): | | | | CAWEM  CAWEX  OHP  Private  Other State’s Medicaid  Other  None | | | Current WIC client: | | Yes  No  Scheduled |
| App. submitted date: | | | Click or tap here to enter text. | | Reapply date: | Click or tap here to enter text. | Family number: | | Click or tap here to enter text. |
| Approval: | OHP approved  CAWEX approved  QHP approved | | | | | | Family income: | | Click or tap here to enter text. |
| If OHP, which CCO: | |  | | | | | Notes: | Click or tap here to enter text. | |

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| Services delivered by OMC site | | | | | Date of services: | Click or tap here to enter text. |
| Postpartum care | Postpartum needs screening | |  | | | |
| Postpartum appointment scheduled | | Attendance at postpartum visit confirmed by OMC site | | | |
| Insurance | OHP application assistance | | OHP community partner referral | | | |
| Newborn OHP enrollment | |  | | | |
| Health & social supports | WIC:  Certification  Referral | Primary care provider:  Education  Referral | | Smoking cessation:  Education  Referral | | |
| Home visiting:  Education  Referral | Dental:  Education  Referral | | Transportation assistance:  Education  Referral | | |
| Behavioral health:  Education  Referral | Reproductive health:  Education  Referral | | Breastfeeding:  Education  Referral | | |
|  |  | | Other community referrals | | |

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| Postpartum care information | | | | |
| Did client have postpartum care prior to OMC contact? | Yes (indicate date below): | | OR | No (indicate the date care received after OMC contact below): |
| Click or tap here to enter text. | | Click or tap here to enter text. |
| Name of postpartum care provider or clinic: | | Click or tap here to enter text. | | |

Notes: Click or tap here to enter text.