|  |  |  |  |
| --- | --- | --- | --- |
| **OMC Site Code/Name:** | **Date of Initial Contact:** | **Date of Birth:** | Referred by**\***: |
| **First Name:** | Preferred name**\***: | Phone Number(1st)**\***: | [ ]  home [ ]  cell [ ]  work [ ]  message |
| **Last Name:** | Phone Number (2nd)**\***: | [ ]  home [ ]  cell [ ]  work [ ]  message |
| Street Address**\***: | **Ethnicity:**  [ ]  Hispanic or Latino [ ]  Not Hispanic or Latino [ ]  Declined to Answer [ ]  Unknown |
| Mailing Address**\***: | **Language:** [ ]  Cantonese [ ]  English [ ]  Russian [ ]  Spanish [ ]  Vietnamese [ ]  Other: |
| **City:** | **Zip:** | **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 |
| Email Address**\***: |
| **Current Student?:** [ ]  No [ ]  High School [ ]  Comm Coll [ ]  University [ ]  Other School  If in Community College, Specify Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
|  **Client Screening** |  |
| **LMP Date:** EDD Date**\***: “High Risk” pregnancy: [ ]  |
| Current WIC Client: [ ]  Yes [ ]  No [ ]  ScheduledFamily Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Family Income: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Gravida: \_\_\_\_\_\_\_\_Para: \_\_\_\_\_\_\_\_Abortion: \_\_\_\_\_\_\_\_Living Child: \_\_\_\_\_\_\_\_ | Tobacco User: [ ]  Yes [ ]  NoAlcohol User: [ ]  Yes [ ]  NoDrug User: [ ]  Yes [ ]  NoDomestic Violence: [ ]  Yes [ ]  No | Vitamins: [ ]  Yes [ ]  NoBreastfeeding Plan: [ ]  Yes [ ]  No |

######  **Application Information**

|  |  |
| --- | --- |
| **App. Submitted Date: Reapply Date (same pregnancy):****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Client’s Current Maternity Insurance – (select one)**🌕 CAWEM 🌕 CAWEX 🌕 OHP 🌕 Private Insurance 🌕 Other County’s CCO 🌕 Other State’s Medicaid 🌕 FFM 🌕 Other 🌕 None |
| **Approval:** [ ] OHP Approved [ ]  CAWEX Approved [ ]  QHP Approved |

###### **Services Delivered by OMC Site** *(check appropriate boxes)*

|  |  |
| --- | --- |
| **Date of Services:** | **Appt. Time\*:** |
| [ ]  | Pregnancy Testing | [ ]  | Other Community Referrals  |
| [ ]  | OHP Application Assistance | [ ]  | Attendance at 1st Prenatal Visit before OMC Confirmed |
| [ ]  | Referral to OHP Community Partner | [ ]  | Dental Education/Information [ ]  Completed Dental Referral |
| [ ]  | Prenatal Care Provider Selected | [ ]  | Smoking Cessation Education and Referral |
| [ ]  | PNC Appt. Scheduled/or Confirmed by OMC Site | [ ]  | Behavioral Health Referral Education [ ]  Behavioral Health Referral |  |
| [ ]  | Initial Prenatal Needs Assessment | [ ]  | Primary Care Provider Education/Information |
| [ ]  | WIC Referral/Certification | [ ]  | Primary Care Provider Referral (appt:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) |
| [ ]  | Home Visiting Education/Information [ ]  HV Referral Completed | [ ]  | Transportation Referral and/or Assistance |
|  |  | [ ]  | Childbirth Class Education Enrollment/Referral |
|  **Prenatal Care Information**  |
| **Has client started PNC prior to OMC?** 🌕 Yes \*\* ***(\*\*indicate date below)*** 🌕 No |
| Name of Prenatal Care Provider or Clinic:\* |
| **Date 1st PNC before OMC** *\*\*(If answered Yes above)***:** | **Date PNC after OMC contact:** |
| ***If no date above, select reason below:*** |
| [ ]  Declined[ ]  Lost to follow-up | [ ]  Option Undecided[ ]  Will Make Own Appts | [ ]  Pending OHP Approval[ ]  TAB (Abortion) | [ ]  SAB (Miscarriage)[ ]  Transferred Care | [ ]  Gave Birth[ ]  Pending Clinic Response |

Notes\*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Form Complete?**

**Yes 🞏 No 🞏**