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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 |
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| 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.