Prenatal Care Coordination Initial Assessment Form Operational Guidelines | 2010

Overview

Case Management Services for Pregnant Women are defined by Indiana Administrative Code, (405 IAC 5-11-1).

"Case Management Services for Pregnant Women" means an active, ongoing process of assisting the individual to identify, access, and utilize community resources and coordinating services to meet individual needs. The term includes:

(1) Locating service sources;
(2) Making appointments for service;
(3) Arranging transportation to services; and
(4) Following up to verify appointments or reschedule appointments
(405 IAC 5-11-1)

Billing Requirements for Medicaid

An Initial Assessment - Code H1000

Must be completed by a Certified Prenatal Care Coordinator and contain the following:

- Initial Assessment Form, where risk is determined
- Development of individualized plan of care
- Referral and linkage to appropriate support/community services
- Scheduled follow-up/monitoring

All eligible pregnant women may receive initial assessment; however ongoing prenatal care coordination services, only those women deemed at risk for low birth weight or poor pregnancy outcome. Documentation of risk status must be maintained.

The initial assessment is limited to one unit per pregnancy. Each unit must include **two (2)** documented encounters, one of which must be a home visit or a face-to-face encounter. If client refuses home visit/face-to-face encounter the visit may occur at an alternate location. Client refusal of home visit and alternate location must be documented in client's file. Additional encounters must be documented in the client's record.

There is a considerable amount of information to be gathered in order to provide comprehensive services to Medicaid eligible women. Prenatal Care Coordinators are expected to work collaboratively with each client's healthcare providers and Medicaid Managed Care Organization (MCO) to ensure alignment of services. Failure to complete all fields that apply to individual members may result in denial of claim.

A ***Letter of Findings*** describing assessment results related to the current pregnancy must be submitted to each client's health care provider and MCO within fourteen (14) calendar days from the date of service or within three (3) business days of discovering a client's known eligibility with an MCO.

Field Descriptions

The guidelines below are provided to clarify field definitions for questions on the Initial Assessment form. Completion of the Initial Assessment form captures vital information needed to determine risk level and provide support services during the prenatal period of pregnancy.

Prenatal care coordinators must maintain a copy of the completed Initial Assessment form in the client's file. The completed form does not need to be submitted to OMPP, ISDH or the woman's MCO, but may be subject to audit by any of these agencies.

Bold/Shaded areas denote high risk factors. This will assist in identifying if the woman is at risk for a low birth weight baby or poor pregnancy outcome; therefore, qualify her for continuing prenatal care coordination services.

Prenatal Care Coordination Initial Assessment Form Field Descriptions

MATERNAL IDENTIFYING INFORMATION		
Field	**Description**	**Definition**
1.	PNCC Agency	Enter Agency name
1a.	Address	Enter Agency address information
1b.	Contact person	Enter name of Prenatal Care Coordinator working with this client
1c.	Telephone number XXX-XXX-XXXX	Enter Agency telephone number
1d.	Fax number XXX-XXX-XXXX	Enter Agency fax number
2.	MCO	Check the MCO that the member is enrolled at time of assessment. Leave check boxes blank if she is not enrolled with an MCO at the time of assessment. The prenatal care coordinator must work collaboratively with the prenatal healthcare provider and the MCO to assure continuity of care. It is the responsibility of the prenatal care coordinator to contact the MCO to inform them of the care coordination relationship with their member. The prenatal care coordinator must include the pre-notification number from the MCO contact with each billing form (when applicable).
2a.	MCO Contact person	Enter name of MCO contact working with prenatal care coordination. Leave field blank if she is not enrolled with an MCO at the time of assessment.
2b.	MCO Telephone number XXX-XXX-XXXX	Enter MCO contact's telephone number. Leave field blank if she is not enrolled with an MCO at the time of assessment
2c.	MCO Fax number XXX-XXX-XXXX	Enter MCO's fax number. Leave field blank if she is not enrolled with an MCO at the time of assessment
2d.	MCO Pre-Notification number	The prenatal care coordinator must include the pre-notification number from the MCO contact with each billing form (when applicable). Leave field blank if she is not enrolled with an MCO at the time of assessment
3.	Date of 1st Encounter - MM/DD/YY	Date when first encounter was completed.
3a.	Type of encounter	Check the appropriate box for the type or place of the

		encounter.
4.	Date of 2nd Encounter - MM/DD/YY	Date when second encounter was completed. (Leave blank if completing first encounter).
4a.	Type of encounter	Check the appropriate box for the type or place of the encounter.
SECTION I — GENERAL INFORMATION - MEMBER		
5.	Name	**Last:** record the member's last name as found on her Hoosier Healthwise Card, Social Security card, birth certificate or other **legal document**. Check for correct spelling. **MI**: record the member's middle initial **First:** record the member's first name the same as the last name. Check for correct spelling. **Maiden:** what was the member's last name by birth? **DO NOT USE NICKNAMES**.
5a.	RID	Enter the member's 12-digit member identification number (Medicaid number) as it appears on her Hoosier Healthwise Card. Medicaid eligibility can be determined by calling the automated voice response (AVR) system at (317) 692-0819 or 1-800-738-6770. If the member is not enrolled in Medicaid at the time of the initial assessment, complete this field during a subsequent visit. ***Outcome Report#3***
6.	Race	Check the box of the race of the member as identified by the member. ***Outcome Report #6***
7.	Date of Birth- MM/DD/YYYY	Record the member's date of birth. ***Outcome Report #4***
8.	Age	Record member's age in years. If member is less than (<)16 years old, this **indicates a high risk pregnancy**; underage pregnancy require CPS referral as follow-up. If member is less than (<)18 years old, **this indicates a high risk pregnancy.** Record guardian information (name, address) for all members under 18 years old. (Item # 18) ***Outcome Report #4a***
9.	Education	Check the appropriate box describing the number of years of formal education completed by the member. If she has completed fewer than (<)10th grade, this **indicates high risk pregnancy.** Make note of number of years of education in narrative notes section. ***Outcome Report #5***
10.	Ethnicity	Ethnicity pertains to the mother's heritage. Ethnicity is not the same as race. Check whether the mother identifies herself as Hispanic (Spanish, Latino, Mexican, South

		American) or non-Hispanic (not of Spanish decent.) ***Outcome Report #6a***
11.	Primary language	Indiana has seen an increase in Hispanic, Asian, Burmese, Somalian, and Middle Eastern populations. Often English is not the first language of people immigrating to Indiana. Just because a member may speak fairly good English does not mean she can read and understand English which can lead to miscommunication of health needs, treatments, education, etc. The care coordinator should try to provide materials in the language the mother will understand or provide an interpreter. Check the box of the member's primary language. If another language, list the member's response. A response of Spanish or other language may **indicate a high risk pregnancy.** ***Preferred language on *Outcomes Report #7***
12.	Address	Record member's address, include street number, city, state and zip **(Homelessness is a high risk factor**)
13.	Marital status	Check the appropriate box. The mother's marital status may not necessarily relate to the mother's relationship to the baby's father. **Single or Divorced indicates high risk pregnancy.** ***Outcome Report #8***
14.	County	Enter the member's county of residence. ****Outcome Report #2***
15.	Phone	Enter the member's telephone number, note if she has additional telephone number(s) she can be reached at (Cell phone number)
16.	E-mail address	Enter the member's e-mail (if available)
17.	What is the best way to contact you?	Enter the member's response.
17a.	What is the best time to contact you?	Enter the member's response.
18.	Guardian Name	For member's less than (<) 18 years old, enter the name of their legal guardian.
18a.	Relationship	For member's less than (<)18 years old, enter the relationship of their legal guardian.
19.	Address	For member's less than (<)18 years old, record address, include street number, city, state and zip of their legal guardian. **(Homelessness is a high risk factor)**
20.	Phone 1	For member's less than (<) 18 years old, enter the first telephone number for contacting their legal guardian.
20a.	Phone 2	For member's under 18 years old, enter any additional telephone number for contacting their legal guardian. (if applicable)
21.	Emergency Contact: Name	Enter the name of a person to contact in an emergency
22.	Emergency Contact: Address	Enter the address of the person to contact in an emergency
22a.	Emergency Contact: Phone	Enter the telephone number of the person to contact in an

		emergency
23.	Medical Provider or Clinic	Enter the name of the physician/provider that the member is seeing during this pregnancy. Include telephone and fax number. If she does not have a medical healthcare provider, assist her in finding prenatal care services.
24.	Insurance Status	Check the appropriate box describing the type of health coverage the member reports.
SECTION II – CURRENT PREGNANCY		
25.	Last Menstrual Period?	Enter date of member's last menstrual period.
26.	Estimated date of Conception?	Enter date of member's estimated date of conception.
27.	EDC	Enter member's estimated date of confinement (EDC) or due date.
28.	When was your first medical appointment for prenatal care?	Enter the first time the member sought medical care for pregnancy. Enter the number of weeks of pregnancy the member was at first doctor visit, i.e. 1-40 weeks pregnant. ***Outcome Report #9***
29.	I have not seen anyone yet.	Check box if applicable.
30.	I have an appointment set for MM/DD/YYYY	Check box if applicable. Enter date of visit as MM/DD/YY. If first visit has not occurred enter NA and provide support to get her into prenatal care.
31.	I have been to the ER 2 or more time during this pregnancy	Check **yes** if the member has visited the emergency room more than twice for care for herself, for any reason during the pregnancy. Check **no** if she did not visit the emergency room for care. 2 or more ER visits indicates high risk pregnancy. ***Outcome Report #11***
32.	If you could change the timing of this pregnancy, when would you want it?	Check the member's response. Unplanned or unwanted pregnancy can affect the mother's compliance with prenatal care and pregnancy outcomes. A response of "not at all" **indicates a high risk pregnancy.** ***Outcome Report #22 & 31***
33.	Are you pregnant with more than one baby?	Check the member's response. If response is "yes" ask question 33a. More than one fetus **indicates high risk pregnancy** ***Outcome Report- Multiple Gestation #22***
33a.	If yes, how many?	Record number per member's response.
34.	How many times have you been to a dentist or dental clinic in the last two years?	Record member's response. Poor dental hygiene and periodontal disease can cause preterm labor. ***Outcome Report #22***
35.	Are you thinking about breastfeeding your baby?	Check the member's response.
36.	Have you had an HIV test during this pregnancy?	Check the member's response. By law all pregnant women are to have a test for HIV unless they opt out. If the mother states she has not had one, tell her to discuss it with her doctor. If the mother has not started prenatal care yet educate her about the test.
SECTION III – PREGNANCY HISTORY		
37.	First Pregnancy?	If this is the member's first pregnancy, check box and skip to Section IV.

38.	How many times have you been pregnant before?	Ask how many times have you been pregnant including miscarriages and abortions? Enter member's response.
39.	Number of full term babies:	Full term is 37 weeks or greater gestation. Enter member's response.
40.	Number of babies born more than 3 weeks early	Preterm delivery is up to 36.6 weeks. Women who have had previous preterm deliveries are at greater risk of having a subsequent preterm delivery. The more preterm deliveries a woman has had the greater the risk for a subsequent preterm delivery. **(Response may indicate current high risk pregnancy).** Enter member's response.
41.	Number of pregnancy loss at less than 20 weeks	In Indiana a pregnancy loss prior to 20 weeks (5 months) gestation is considered a miscarriage. Enter member's response.
42.	Number of pregnancy loss at 20 or more weeks	A pregnancy loss at 20 or more weeks gestation is a fetal death. **(Response may indicate current high risk pregnancy).** Enter member's response.
43.	Number of living children	Of the total number of births this member has had, how many are living? Enter member's response.
44.	Number of babies weighing less than 5 ½ pounds at birth	Low birthweight is less than 2500 grams or 5 ½ pounds. A mother who has had a previous low birthweight infant is at risk for having another low birthweight baby. **(Response may indicate current high risk pregnancy).** Enter member's response.
45.	Number of babies weighing more than 9 pounds at birth	Women who deliver large babies may have gestational diabetes even if they were diagnosed during the previous pregnancy. Ask how much the mother and father weighed at birth to rule out familial tendency of large babies. Enter member's response.
46.	Number of babies weighing less than 3 ½ pounds at birth	Birthweight less than 1500 grams or 3 ½ pounds is considered very low birthweight. A mother who has had a previous low birthweight infant is at risk for having another very low birthweight baby. **(Response may indicate current high risk pregnancy)** Enter member's response.
47.	Date and outcome of last pregnancy?	Check appropriate box from member's response. "Stillbirth" response **indicates current high risk pregnancy**
SECTION IV – NUTRITION/WEIGHT/BMI The purpose of the NUTRITION/WEIGHT/BMI section is four-fold: 1) examine nutrient intake; 2) assess the sources of energy/calories that might contribute to weight management; 3) review food safety; and 4) encourage physical activity.		
48.	Since you have been pregnant how have your eating habits changed?	Engage member into discussion on eating habits. Check member's response, and describe as needed. Additional notes can be recorded in the narrative notes section.
49.	During the past month, did you miss any meals, not eat when you were hungry, or use a food pantry because there was not enough food or money to buy food?	Food (energy) restriction during pregnancy can put the fetus at metabolic risk. Check "Yes" if any of the situations are true and briefly describe the circumstances. "Yes" response **may indicate high risk pregnancy.** ***Outcome Report #22***

50.	Indicate any problems?	Check appropriate box and describe situations.
51.	Are there any foods you are allergic to or avoid eating?	Enter member's response. Foods may be avoided due to food aversions, cultural reasons or personal dislike. Note the food(s) avoided and note whether the avoidance involves an entire food group, such as dairy. **Response may indicate high risk pregnancy**
52.	Are you taking any vitamin/mineral/dietary/botanical supplements?	List any supplements that the client is taking, including prenatal vitamins. Be sure to probe for supplements that the client might be using to treat nausea or any other pregnancy-related symptoms. Dietary supplements, other than those prescribed by the healthcare provider may not be safe during pregnancy. **Response may indicate high risk pregnancy**
53.	Have you eaten or had any cravings for non-food items?	Ask this question to determine whether the client has craved or consumed non-food items. Be sure to include "ice" as in this circumstance it is considered to be a non-food item. The consumption or craving of non-food items can be a signal of iron-deficiency/anemia. Record member's response; if "Yes", **indicates high risk pregnancy.**
54.	Cultural preferences affecting nutrition	Record member's response; if "Yes", **indicates high risk pregnancy.**
55.	History of weight loss surgery?	Record member's response; if "Yes", **indicates high risk pregnancy.**
56.	History of Eating Disorder?	Record member's response; if "Yes", **indicates high risk pregnancy.**
57.	Mother's birthweight	A mother who was born at a low birthweight is at higher risk of having a low birthweight baby. Record the mother's weight at birth as pounds and ounces. Low or very low birthweight **indicates high risk pregnancy.** ***Outcome Report #12***
58. Diet Intake/Physical Activity Record and Diet Assessment/Evaluation – Check all that apply (Use www.mypyramid.gov for additional information.) This section provides an opportunity to record and assess the participant's dietary habits. For any item checked in the Diet Assessment/Evaluation area, take the time to discuss the importance of this food group/area with the client. Allow the client to select areas where they feel they can make an improvement in their dietary habits. Assist the client in setting goals that are SMART (Specific, Measurable, Achievable, Reasonable and Time-oriented). Document these goals in the care plan and review with the client on subsequent visits. Once initial goals have been achieved other nutritional goals can be set		
a.	How often do you eat foods from the dairy group? (3 or more times a day - ex. milk, yogurt, cheese, cottage cheese) and Inadequate diary intake	Check the "yes" box if consumption is 3 or more times a day; otherwise check no and check the related "Inadequate dairy intake" box. Note details provided by client.
b.	How often do you eat fruit? (More than 4 times a day - ex. apples, bananas, oranges, grapes, etc) and Inadequate fruit intake	Check the "yes" box if consumption is 4 or more times a day; otherwise check no and check the related "Inadequate fruit intake" box. Note details provided by client.
c.	How often do you eat vegetables? (5 or more times a day - ex: broccoli, spinach, greens, salad, V-8 juice, etc) and Inadequate vegetable intake	Check the "yes" box if consumption is 5 or more times a day; otherwise check no and check the related "Inadequate vegetable intake" box. Note details provided by client.

d.	How often do you eat foods from the meat & beans group? (more than 3 times a day - ex: meats, fish, eggs, peanut butter) and Inadequate meat/bean intake	Check the "yes" box if consumption is 3 or more times a day; otherwise check no and check the related "Inadequate meat/bean intake" box. Note details provided by client.
e.	How often do you eat foods from the grains group? (6 or more times a day - ex: cereal, rice, pasta, bread, tortillas, pita bread, bagels, crackers) and Inadequate grain intake	Check the "yes" box if consumption is 6 or more times a day; otherwise check no and check the related "Inadequate grain intake" box. Note details provided by client.
f.	How often do you drink a glass or bottle of water? (8 or more times a day) and Inadequate fluid intake	Check the "yes" box if consumption is 8 or more times a day; otherwise check no and check the related "Inadequate fluid intake" box. Note details provided by client. **Response may indicate high risk pregnancy.**
g.	How often do you drink sweetened drinks? (More than 1 per day - ex: pop, Kool Aid + sugar, Snapple, energy drinks) and Excess intake of sugar-sweetened drinks	Check the "yes" box if consumption is 1 or more times a day and check related "Excess intake of sugar-sweetened drinks" box; otherwise check no. Note details provided by client.
h.	How often do you drink coffee, tea, cocoa, colas or eat chocolate? (More than 3 beverages a day-includes energy & diet drinks) and Excess intake of caffeine	Check the "yes" box if consumption is more than 3 times a day and check related "Excess intake of caffeine"; otherwise check no. Note details provided by client.
i.	How often do you eat bakery goods or snack items? (More than 5 times a day - ex: doughnuts, pop tarts, cookies, chips, candy) and Excess intake of high-energy (calorie) or high fat foods/beverages	Check the "yes" box if consumption is more than 5 times a day and check related "Excess intake of high-energy (calorie) or high-fat foods/drinks"; otherwise check no. Note details provided by client.
j.	Do you eat luncheon meats or soft cheeses? (Ex: consumes lunch/deli meats, feta, brie, non-pasteurized cheeses) and Food Safety Issues	Check the "yes" box if client consumes these foods and check "Food Safety Issues"; otherwise check no. Note details provided by client.
k.	How often do you eat out or get carry-out? (More than 10 times a week - ex: Fast food, Dine-in, Grab & Go) and Excess intake of convenience foods, pre-prepared meals, foods prepared away from home.	Check the "yes" box if consumption is more than 10 times a week and check related "Excess intake of convenience foods, foods prepared away from home"; otherwise check no. Note details provided by client.
l.	How much time do you spend in physical activity? (30 minutes or more a day - ex: walking/walk to work, dancing, running, swimming) and Inadequate physical activity	Check the "yes" box if client spends 30 minutes of more in some sort of physical activity; otherwise check no and check "Inadequate physical activity". Note details provided by client.
59.	On a scale of 0 to 10, how would you feel about making ANY changes to your eating habits or lifestyle?	Circle member's response.

60.	Do you have any questions or concerns about your weight or eating habits?	Check box that matches member's response. List details in narrative notes section.
61.	Are you receiving nutrition services from WIC?	Check box that matches member's response.
62.	Weight before pregnancy	Enter member's response. ***Outcome Report #13***
62a.	Current weight	Enter appropriate response. This weight should be what the client currently weighs and should be measured via scale (verses self-reported). ***Outcome Report #14-Use pre-pregnancy weight and current weight to determine total weight gain for reporting.***
62b.	Height	Check box that matches member's response. Ideally this should be measured in a clinic or health care provider's office. ****Outcome Report #13a***
63.	Pre-pregnancy BMI http://www.nhlbisupport.com/bmi/	Check box that matches member's response. Note that BMI should be computed based on pre-pregnancy weight and height. Use chart to determine BMI and then record in this box. BMI results **may indicate high risk pregnancy.** ****Outcome Report #13b***
a.BMI < 18.5	Check this box if the client's pre-pregnancy BMI is <18.5	Discuss the weight gain recommendations of 28 to 40 pounds with the client. Stress the need to gain this amount of weight to reduce the risk of health problems in the baby.
b.BMI is 18.5 to 29.4	Check this box if the client's BMI is between 18.5 and 29.4.	Discuss with the client the need to manage weight gain between 25 to 35 pounds.
c.BMI is 25.0 to 29.9	Check this box if the client's BMI is between 25.0 and 29.9	Discuss with the client the need to manage weight gain between 15 to 25 pounds.
d.BMI is ≥ 30.0	Check this box if the client's BMI is computed at greater than or equal to 30.0.	Discuss with the client the need to manage weight gain between 11 to 20 pounds.
SECTION V – PREGNANCY CONCERNS		
64.	Do you have or have you ever had any of the following conditions?	Check all that apply **Shaded conditions on the form may indicate high risk pregnancy. *Outcome Report #22***
65.	Do you have dental pain or bleeding when you eat or brush your teeth?	Check box that matches member's response. **A "Yes" response may indicate high risk pregnancy.** ***Outcome Report #22***
66.	Have you had any bleeding or cramping?	Check box that matches member's response. **A "Yes" response may indicate high risk pregnancy.**
SECTION VI - SUBSTANCE USE		
67.	In the past year, have you ever drank, smoked or used drugs more than you meant to?	Check box that matches participant's response. **A "Yes" response indicates high risk pregnancy.**
68.	Have you felt you needed to cut back on your drinking, smoking or drug use in the past year?	Check box that matches participant's response. **A "Yes" response indicates high risk pregnancy.**
69.	Did either of your parents have a problem with alcohol or drugs?	Check box that matches participant's response. **A "Yes" response indicates high risk pregnancy.**
70.	Do any of your friends (peers) have	Check box that matches participant's response. **A "Yes"**

	a problem with alcohol or drugs?	**response indicates high risk pregnancy.**
71.	Does your partner have a problem with alcohol or drugs?	Enter participant's response. **A "Yes" response indicates high risk pregnancy.**
72.	Have you had a problem with alcohol or drugs in the past?	Enter participant's response. **A "Yes" response indicates high risk pregnancy.**
73.	Have you smoked any cigarettes, used alcohol or any drugs in this pregnancy?	Enter participant's response. **A "Yes" response indicates high risk pregnancy.**
74.	Does anyone else in your household smoke cigarettes?	Check box that matches participant's response. Exposure to secondhand smoke during pregnancy may indicate **high risk pregnancy.** ***Outcome Report***
75.	Stage of change	Check box that matches participant's response
SECTION VII – PSYCHOSOCIAL		
Questions 76-81 assess for domestic violence, physical, mental or sexual abuse. These questions are recommended by the ISDH Office Of Women's Health Rape And Abuse Prevention Program. The questions are repeated in several different ways. These repeated questions have been to be effective in studies. If the mother answers yes to the first questions do not keep asking all of the questions.		
76.	In the past year have you been hit, slapped, kicked or otherwise physically hurt by someone?	Check box that matches participant's response. If "Yes" explore further as to whom, when, how often, last incidence. Give mother information about domestic violence and resources. **A "Yes" response indicates high risk pregnancy. *Outcome Report***
77.	Since you have been pregnant have you been hit, slapped, kicked or otherwise physically hurt by someone?	Check box that matches participant's response. If "Yes" explore further as to whom, when, how often, last incidence. Give mother information about domestic violence and resources. **A "Yes" response indicates high risk pregnancy. *Outcome Report***
78.	Within the last year has anyone made you do something sexual that you did not want to?	Check box that matches participant's response. If "Yes" explore further as to whom, when, how often, last incidence, is she safe now. Provide support, education and referral to a women's shelter if appropriate. **A "Yes" response indicates high risk pregnancy. *Outcome Report***
79.	Are you afraid of your partner or anyone else?	Check box that matches participant's response. If "yes" refer participant to a shelter or the police. **A "Yes" response indicates high risk pregnancy. *Outcome Report***
80.	Does your partner ever humiliate you? Shame you? Put you down in public? Keep you from seeing friends or family?	Check box that matches participant's response. If "Yes' explore further as to whom, when, how often, last incidence, is she safe now. Provide support, education and referral to a women's shelter if appropriate. **A "Yes" response indicates high risk pregnancy.**
81.	Have you ever been physically, sexually, emotionally, or verbally abused by your partner or someone close to you?	Check box that matches participant's response. **A "Yes" response indicates high risk pregnancy. *Outcome Report***
82.	Do you feel safe in your neighborhood?	Check box that matches participant's response. **A "No" response indicates high risk pregnancy.** An unsafe neighborhood is a cause of stress and may be a cause for missed appointments. ***Outcome Report***
83.	Have you had any problems with	Check box that matches participant's response.

	housing in the past three months?	**A "Yes" response indicates high risk pregnancy.** If the participant is having housing problem refer her to community resources as needed. A history of housing problems, such as, evictions, foreclosure, frequent moves indicates ongoing issues that may require PNCC assistance with finding resources to meet the family's needs. Ask for other sources of contact so you can reach her if she has to move again. ***Outcome Report**
84.	Have you ever been homeless?	Check box that matches participant's response. **A "Yes" response indicates high risk pregnancy.** Let the participant know that if this should become a problem during her pregnancy, she should let you know so you can assist her with housing resources.
85.	Do you have problems with utilities, appliances, bedding, furniture, food, clothing or other things?	Check box that matches participant's response. **A "Yes" response indicates high risk pregnancy. A**ssist with appropriate referrals to meet the needs of the participant. If she is struggling to provide basic needs, she will be more likely to enter care late and not keep appointments. ****Outcome Report***
86.	Do you have transportation, child care, or other problems that prevent you from keeping your health care or social services appointments	Check box that matches participant's response. **A "Yes" response indicates high risk pregnancy.** Once barriers are identified, provide appropriate referrals to assist the participant in keeping appointments. ***Outcome Report***
86a. 86b. 86c.	☐ Transportation ☐ Childcare ☐ Other	Check box that matches participant's response.
The next four questions assess the mother's level of stress and mental state. Research shows that pregnant women with high stress are at high risk for preterm delivery or other pregnancy problems. Pregnant women with a history of mental health disease or depression are at higher risk. ***Outcome Report***		
87.	How would rate your level of stress?	Check box that matches participant's response. **A "High" or "Medium" response indicates high risk pregnancy.**
88.	Lately, have you felt sad or down, have problems sleeping or eating, are unable to enjoy things most of the day, nearly every day?	Check box that matches participant's response. **A "Yes" response indicates high risk pregnancy.** ***Outcome Report***
89.	Have you had problems with depression or received counseling or medication for depression, anxiety or other mental health concerns?	Check box that matches participant's response. **A "Yes" response indicates high risk pregnancy.** ***Outcome Report***
90.	Have you experienced any of these major changes in your life in the past year? (Check all that apply)	Check box that matches participant's response. **Bold/Shaded response indicates high risk pregnancy.** ***Outcome Report***
91.	Do you have family living close by?	Check box that matches participant's response. **A "No" response indicates high risk pregnancy.**
92.	Is the father of your child involved?	Check box that matches participant's response. **A "No" response indicates high risk pregnancy.**

93.	Do you live alone?	Check box that matches participant's response. **A "Yes" response indicates high risk pregnancy.** ***Outcome Report***
94.	Do you have a reliable phone?	Check box that matches participant's response. **A "No" response indicates high risk pregnancy.** ***Outcome Report***
95.	How many people can you count on when you need help?	Check box that matches participant's response. **A "0" response indicates high risk pregnancy.** ***Outcome Report***
96.	Do you feel your support at this time in your pregnancy is	Check box that matches participant's response.
97.	Is there one person that is always there for you?	Check box that matches participant's response. List name and relationship of support system. **A "No" response indicates high risk pregnancy.** ***Outcome Report***
98.	Which of these things worries you a lot?	Check box that matches participant's response. **Bold/Shaded response indicates high risk pregnancy.**
99.	What worries you the most?	Record pertinent information to allow for follow-up and connection to resource.
100.	What do you do to deal with your problems?	Record pertinent information to allow for follow-up and connection to resource.
SECTION VII – NARRATIVE NOTES		Keep narrative notes in this section. Date and clearly indentify question (by number) for reference to follow-up
SECTION IX INDIVIDUALIZED CARE PLAN		Work with the member to identify problems, develop goals and put a plan in action. Review and revise this section once goals are met and/or new goals are identified.
SECTION X REFERRALS		Keep record of referrals provided to member. Include date when referral is provided. Make note if follow-up occurs. ***Outcome Report #24***
SECTION XI EDUCATION TOPICS		Keep record of educational information that is requested and provided to the member.
SECTION XII– TO BE COMPLETED BY HEALTH PROFESSIONAL		All eligible women may receive initial assessment services; however only those deemed at risk for low birth weight or poor pregnancy outcome, are eligible for Prenatal Care Coordination Services. Prenatal Care Coordinator must determine, based on the information documented within the Initial Assessment, whether or not the member is eligible for Prenatal Care Coordination Services. When an initial assessment determines a pregnancy is not at risk, reassessment and postpartum assessment will not be covered services. However, services may be covered later in pregnancy if risk factors from the prenatal risk assessment form, which were not evident or present during the initial assessment, are discovered.
FIRST ENCOUNTER		Signature of staff person completing the initial assessment should be recorded and dated upon completion of prenatal care coordination services visit.
SECOND ENCOUNTER		Signature of staff person completing the second encounter of the initial assessment should be recorded and dated

	upon completion of prenatal care coordination services visit.