|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **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  Scheduled  Family Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Family Income: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Gravida: \_\_\_\_\_\_\_\_  Para: \_\_\_\_\_\_\_\_  Abortion: \_\_\_\_\_\_\_\_  Living Child: \_\_\_\_\_\_\_\_ | Tobacco User:  Yes  No  Alcohol User:  Yes  No  Drug User:  Yes  No  Domestic Violence:  Yes  No | | | Vitamins:  Yes  No  Breastfeeding 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 🞏**