# Oregon MothersCare Assessment, Services, and Application Tracking Form

State ID | Local ID | Last Name | First Name | Middle Name

Date of Birth | Sex ☐ Female ☐ Male | ☐ Confidential address? ☐ Confidential telephone? ☐ Update to address / telephone?

Physical Address | Apt. No. | City, Oregon | ZIP

Physical Address Type ☐ Home ☐ Temporary ☐ Homeless ☐ No address

Mailing Address (if different from physical address) | Apt. No. | City, Oregon | ZIP

Mailing Address Type ☐ Home ☐ Temporary ☐ Homeless ☐ No address

Primary Telephone No. | Alternate Telephone No.

Primary Telephone Type ☐ Home ☐ Work ☐ Message ☐ Cellular ☐ None

Race / Ethnicity (check all that apply) ☐ Hispanic ☐ Non-Hispanic

☐ White ☐ Black or African American ☐ American Indian or Alaska Native

☐ Asian ☐ Native Hawaiian or Pacific Islander ☐ Unknown ☐ Other ___________

Spoken Language (preferred) | Written Language (preferred)

OHP No. | SSN

Guardian Last Name

Guardian First Name | Guardian MI

Guardian Address (if different from Client's)

City, Oregon | ZIP

Guardian Type

Income | Income Interval ☐ Week ☐ Bi-monthly ☐ Month ☐ Annual | Family Size

Concurrent Program Enrollment ☐ Healthy Start ☐ WIC ☐ NFP ☐ Babies First ☐ OMC ☐ MCM ☐ CaCoon

Insurance ☐ OHP Standard ☐ OHP Plus ☐ CAWEM ☐ Private ☐ Military ☐ Veterans ☐ Open Card ☐ None | If no insurance, reason?

Date Referred / Applied to OHP | OHP Status ☐ Enrolled ☐ Referred / Applied ☐ Refused | Reason if OHP declined coverage ☐ No Proof ☐ Not Eligible ☐ Not Covered

Client's Primary Medical Care Provider ☐ None ☐ Referred ☐ Refused ☐ No resource ☐ Current with preventive care

Client's Primary Dental Care Provider ☐ None ☐ Referred ☐ Refused ☐ No resource ☐ Current with preventive care

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Who referred applicant to this program?
☐ WIC ☐ Babies First! ☐ Cacoon ☐ OMC ☐ MCM
☐ Other PH ☐ Healthy Start ☐ SafeNet ☐ NFP
☐ FP Clinic ☐ Hospital ☐ EI ☐ Self ☐ Other _______________

Case Start Date

OMC Contact Name

## Assessment and Services Provided

Initial Service Date | Insurance ☐ OHP Std ☐ OHP Plus ☐ CAWEM ☐ Private ☐ Military ☐ Veterans ☐ Open Card ☐ None | If no insurance, will applicant apply for ☐ OHP Plus ☐ CAWEM

If private insurance, is pregnancy ☐ Covered ☐ Not Covered ☐ Covered, but deductible too high | Prenatal care started? ☐ Yes (local) ☐ Yes (not local) ☐ No ☐ Prenatal Visit Scheduled

First Local PNC Visit Date | Name of Local Prenatal Care Provider | First Non-Local PNC Visit Date (If applicable)

Has applicant arranged for dental care during pregnancy? ☐ Yes (local) ☐ Yes (not local) ☐ No ☐ Visit Scheduled | Name of Local Dental Care Provider | Dental Visit Date

Date of Last Menstrual Period | Confirmed pregnancy? ☐ Yes ☐ No (includes home pregnancy test) | Pregnancy Test Date | Estimated Due Date



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| Last Name | First Name | Middle Name | Date of Birth |
|---|---|---|---|
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## Referrals and Services

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|---|---|---|---|---|
| WIC | ☐ Referred | ☐ Not needed | ☐ Refused assistance | |
| Maternity Case Management | ☐ Referred | ☐ Not needed | ☐ Refused assistance | ☐ Not available |
| Healthy Start | ☐ Referred | ☐ Not needed | ☐ Refused assistance | ☐ Not available |
| Other ______________________________ | ☐ Referred | ☐ Not needed | ☐ Refused assistance | |
| Pregnancy Testing | ☐ Referred | ☐ Not needed | ☐ Provided | |
| Prenatal Care Provider | ☐ Selected | ☐ Already has local provider | ☐ Not selected | ☐ Refused assistance |
| 1st Prenatal Care Appointment (local) | ☐ Scheduled | ☐ Completed | ☐ Client will schedule | ☐ Refused assistance |
| Referral Faxed to Prenatal Care Provider | ☐ Yes | ☐ No | ☐ Not Applicable | |
| Prenatal Care Appointment | ☐ Confirmed | ☐ Not confirmed | | |
| Prenatal Care Appointment Attendance | ☐ Attended | ☐ No Show | ☐ Rescheduled | PNC Appt Rescheduled Date |
| Dental Care Organization Referral | ☐ Referred | ☐ Already has local provider | ☐ Client will schedule an appointment | |
| Dental Care Appointment | ☐ Confirmed | ☐ Not confirmed | | |
| OHP Application Assistance / Referral | ☐ Yes | ☐ No | | |
| Date Stamped | Date Stamped | | | |
| OHP Verification Form Faxed to OHP | Date Verification Form Faxed | | | |

## Application Tracking

| | | |
|---|---|---|
| OHP Application Pending Date | Date OHP Application Pended | |
| OHP Application Resubmitted to OHP | Date OHP Application Resubmitted | ☐ Sent to OHP Central ☐ Sent to OHP Branch |
| OHP Application Rerouted Date | Date OHP Application Rerouted | |
| OHP Application Approved Date | Date OHP Application Approved | |
| CAWEM Application Approved Date | Date CAWEM Application Approved | |
| OHP Application Denied Date | Date OHP Application Denied | Reason Denied ☐ No Proof ☐ Not Income Eligible ☐ Not Covered |



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| Last Name | First Name | Middle Name | Date of Birth |
|---|---|---|---|
| | | | |

Client Status at Final Contact ☐ On OHP / CAWEM ☐ Moved out of area ☐ Lost to Follow-up ☐ SAB ☐ TAB

| OMC Contact Name | OMC Final Service Date (completion date) |
|---|---|
| | |

| Case Notes |
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| Visit Date | OMC Contact | Visit Closed? |
|---|---|---|
| | | ☐ |