COLORADO
Department of Health Care Policy & Financing

303 E. 17th Avenue
Denver, CO 80203

Prenatal Plus Intake Form

Updated September 2023

Member Name _____
Date of Birth _____/_____/_____
EDD _____/_____/_____ Date of Enrollment _____/_____/_____
Weeks Gestation at Enrollment _____ Medicaid #_____
Pronouns _____

Medicaid member is at risk of poor maternal and/or infant health outcome(s) due to at least one (1) of the following (check all that apply):

- ☐ History of previous low birth weight infant
- ☐ Age 18 or younger at time of conception
- ☐ Age 35 or greater at time of conception
- ☐ Recent or current alcohol use
- ☐ Recent or current illicit drug use
- ☐ Recent or current smoker
- ☐ Pre-pregnancy BMI less than 18.5 kg/m^2
- ☐ Pre-pregnancy BMI greater than or equal to 30 kg/m^2
- ☐ Recent delivery (12 months prior)
- ☐ Inadequate prenatal weight gain
- ☐ Education level less than appropriate for age
- ☐ Single parent
- ☐ Cognitive or developmental disability
- ☐ Member does not desire the pregnancy or has unresolved feelings regarding the pregnancy
- ☐ Experienced a pregnancy loss
- ☐ History of or current mental health disorder, including depression
- ☐ History of or current domestic violence
- ☐ History of abuse in childhood
- ☐ Incarcerated within the past year, currently on probation or received a felony conviction within past 2-5 years
- ☐ Has been homeless within the past 12 months
- ☐ Moved to the U.S. within past 6 months as a refugee or political asylee
- ☐ English spoken as a 2nd language or lives in a household where English is not the primary language

Medicaid member is at risk of poor maternal and/or infant health outcome(s) due to at least two (2) of the following in the last twelve months (check all that apply):

- ☐ The member had a death of someone very close to them
- ☐ Their partner went to jail
- ☐ Someone very close to them has had drug or alcohol problems
- ☐ A close family member was very sick and had to go into the hospital

- ☐ They are/were separated or divorced from their partner
- ☐ They have moved to a new address in the last 12 months
- ☐ Their partner lost his/her job
- ☐ Lost their lost job
- ☐ They argued with their partner more than usual
- ☐ Partner said he/she didn't want the member to be pregnant
- ☐ The member had a lot of bills they couldn't pay
- ☐ The member was in a physical fight
- ☐ The member lacks social support

_____ **Total stress factors in the last 12 months**

****End form here if the member does not qualify for the program.**

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Nutrition and Exercise

1. During this pregnancy have you had daily or severe nausea or vomiting?
   - ☐ Yes
   - ☐ No

2. Do you have any problems that make eating/drinking difficult?
   - ☐ Yes
   - ☐ No

   If yes, what?

3. If you have been pregnant before, how much weight did you gain with each pregnancy?

4. Do you exercise?
   - ☐ Yes
   - ☐ No

   If yes, what do you do for exercise and how often?

5. Are you on a special diet now such as: low- calorie, low-salt, low-carb, diabetic?
   - ☐ Yes
   - ☐ No

   If yes, why?

6. Do you eat or crave non-food items like clay, laundry starch, paint chips, paper, dirt, or ice?
   - ☐ Yes
   - ☐ No

   If yes, what did you crave/eat, how much and how often?

7. Have you ever run out of food?
   - ☐ Yes
   - ☐ No

8. Do you feel you have enough food now?
   - ☐ Yes
   - ☐ No

9. Have you ever thought or been told you had anorexia or bulimia?
   - ☐ Yes
   - ☐ No

Sources of Income

1. Are you currently working?
   - ☐ Yes
   - ☐ No

2. Do you receive/want to receive any of the following:
   - ☐ Medicaid
   - ☐ TANF
   - ☐ WIC
   - ☐ SNAP

Educational /Vocational Goals

1. Are you currently in school?
   - ☐ Yes
   - ☐ No

   If no, what was the last grade that you finished?

2. Has anyone told you that you have a learning, cognitive, or developmental disability?
   - ☐ Yes
   - ☐ No

3. If you answered yes to #2, would you like help finding resources specific to the disability or disabilities?
   - ☐ Yes
   - ☐ No
   - ☐ N/A

4. Do you plan to work or go to school after the baby is born?
   - ☐ Yes
   - ☐ No
   - ☐ N/A

Social Supports

Who are support people in your life? (i.e., partner, parents, church, doula, friends, coworkers, other relatives)

Living Arrangements/transportation

1. What forms of transportation do you use? _____

2. Where do you live?
   - ☐ apartment
   - ☐ house
   - ☐ shelter
   - ☐ no housing
   - ☐ other _____

3. Does anyone else live with you in your home?
   - ☐ Yes
   - ☐ No

   If yes, please provide the following information:

Name	Age	Relationship to you

4. Do you have any other children who do not live with you?
   - ☐ Yes
   - ☐ No

   If yes, where do they live?

5. How many times have you moved in the past 12 months?

6. Do you think your current housing situation is adequate and safe?
   - ☐ Yes
   - ☐ No

This section may be skipped if the patient has completed a validated substance use screening tool

Please answer the questions honestly so we may help you receive the best possible care for you and your baby.

Do you…	Before Pregnancy	Since getting pregnant
1.Smoke cigarettes?	☐ Yes ☐ No	☐ Yes ☐ No
If yes, how many a day?		
2.Use chewing tobacco?	☐ Yes ☐ No	☐ Yes ☐ No
3.Use e-cigarettes?	☐ Yes ☐ No	☐ Yes ☐ No

4. Does anyone in your home smoke? Or are you around people who are smoking?
- ☐ Yes
- ☐ No

5. If you are currently smoking or have recently used tobacco, please check the best answer below:
- ☐ I do not want to quit
- ☐ I have thought about quitting but I am not ready yet
- ☐ I want to quit soon
- ☐ I recently quit smoking
- ☐ I quit smoking but I have started again
- ☐ I quit smoking and I will not start again
- ☐ N/A

6. How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons (for example, because of the experience or feeling it caused)?

For the following questions a drink equals one 12-ounce beer, one 4-ounce glass of wine or one 1-ounce shot of hard liquor.

7 When was your last drink?
- ☐ this week
- ☐ last week
- ☐ last month
- ☐ months ago
- ☐ never

8. How many drinks does it take for you to feel the effects of alcohol?

9. Have you ever been treated for problems with alcohol?
- ☐ Yes
- ☐ No

If yes, when? _____

10. Would you like help to quit drinking alcohol while you are pregnant and/or breastfeeding?
- ☐ Yes
- ☐ No

11. How often do you use cannabis?
- ☐ Never
- ☐ Monthly or less
- ☐ 2-4 times a month
- ☐ 2-3 times a week
- ☐ 4 or more times a week

12. If yes, when was the last time you used cannabis?
- ☐ this week
- ☐ last week
- ☐ last month
- ☐ months ago
- ☐ never

13. Have you ever thought about cutting down, or stopping, your use of cannabis?
- ☐ Never
- ☐ Yes, but not in the past six months
- ☐ Yes, during the past six months

14. Would you like support in decreasing your substance use (including cannabis) while pregnant and/or postpartum?
- ☐ Yes
- ☐ No

15. Have you ever been treated for problems with illicit drugs/substances?
    - ☐ Yes
    - ☐ No

    If yes, when? _____

16. Does anyone in your home have a problem with drugs or alcohol?
    - ☐ Yes
    - ☐ No

Unintentional opioid overdose is a leading cause of maternal mortality. Would you accept a prescription for Naloxone to keep in your medicine cabinet in case you or someone you know needs to reverse an overdose?
- ☐ Yes
- ☐ No

Resources

The Prenatal Plus Program has helpful information for you during your pregnancy. Please check any topics you would like more information about:

- ☐ breastfeeding and other infant feeding options
- ☐ nutrition
- ☐ exercise
- ☐ assistance getting food
- ☐ work options
- ☐ resources for clothing, baby furniture, etc.
- ☐ financial help
- ☐ school/GED resources
- ☐ housing/shelter
- ☐ heat resources for your home
- ☐ counseling
- ☐ getting along with your partner or family
- ☐ how to prevent a low birthweight or premature baby
- ☐ caring for yourself and your baby after you get home
- ☐ postpartum depression or anxiety
- ☐ quitting smoking
- ☐ secondhand smoke
- ☐ reducing/ quitting drugs or alcohol
- ☐ coping with changes during pregnancy
- ☐ growth and development of your baby
- ☐ parenting
- ☐ childbirth classes
- ☐ labor and delivery
- ☐ birth control methods
- ☐ day care
- ☐ other__

I agree to participate in the_____Prenatal Plus Program.
(Name of Agency)

Member Signature: _____

Date completed: _____

Care Coordinator Signature: _____

Date Reviewed: _____