Infant's Medicaid ID #: ______________________________
Mother's Medicaid ID #: ______________________________ Date of Assessment:____________________
Type: Open Card or Fee For Service_______ Managed Care (MHP):______________________________
Non-Medicaid: Location: ☐ Home Visit ☐ Other Visit
☐ Application in process. Explain______________________ ☐ Office Visit
☐ Not yet applied. Explain ______________________

Has the consent form been signed? ☐YES ☐NO

Maternal Infant Health Program

INFANT INITIAL ASSESSMENT

GENERAL INFORMATION

Infant's First Name _____________ Last Name _____________ Date of Birth ____/_____/____ Race/Ethnicity ________
Mother's First Name _____________ Last Name _____________ Date of Birth ____/_____/____ Race/Ethnicity ________
Primary Caregiver's First Name ______________ Last Name ____________________ Date of Birth ____/_____/____

Phone Number _____________(hm) ___________(wk) Best time to reach caregiver _________
Is there another phone number where you can be reached?______________________________
Current Address ____
Street Address City Zip County
Directions
____
____

Are you?
☐ Single ☐ Married
☐ Divorced ☐ Widowed
☐ Separated ☐ Cohabiting

Circle one: Mother or Primary Caregiver
Employment Status: ☐ Full Time (FT) ☐ Part Time (PT) ☐ Work First ☐ Not Working ☐ Student
Last Grade Completed _______ Race/Ethnicity ________________________________
What language do you prefer to speak? ________________________________
What language do you prefer to use for reading?________________________________

Name of Father of Baby (FOB)________________________Date of Birth ____/_____/____ Race/Ethnicity___________________
Employment Status: ☐ Full Time (FT) ☐ Part Time (PT) ☐ Not Working ☐ Student
Relationship with Mother: ☐ Involved ☐ Not Involved

Household Roster (List names of all members)*	Relationship to Infant	Sex	Race/Ethnicity	Age

*Include husband/partner if different than above; Mother of Baby (MOB) parents/FOB parents; MOB siblings/FOB siblings; MOB other children.

Infant's Name: ______________________________

HEALTH INFORMATION

INFANT HEALTH

1. Gestational Age at Birth _________ Birth Weight __________ Birth Height _________ Head Circumference ______
2. Do you have a medical care provider that accepts Medicaid? ☐ YES ☐ NO
   If no, what kind of problem have you had in selecting a provider?____
   ____
3. Have you had a well child visit with a medical care provider? ☐ YES ☐ NO
   a. Name of medical care provider____
   b. Address/Location____
   c. Infant's age of first appointment ______________________________ Date of next appointment ___________________
4. Has your baby been admitted to the hospital since delivery? ☐ NO ☐ YES
   a. Intensive care ☐ NO ☐ YES
   b. Emergency room ☐ NO ☐ YES
   c. Pediatric Unit ☐ NO ☐ YES
   d. Name of Hospital ____
   e. Reason for admittance ____
5. Has your baby been diagnosed with special needs? ☐ NO ☐ YES
   a. Were there any positive test results from newborn screening? ☐ NO ☐ YES
   b. Is your baby enrolled in Children's Special Health Care Services? ☐ NO ☐ YES
6. Are you satisfied with the medical care your baby is receiving? ☐ YES ☐ NO
   If no, check all the items below that you are not satisfied with:
   ☐ amount of time you had to wait to see the provider
   ☐ amount of time the doctor or nurse spent with you during your visit
   ☐ advice you received on how to take care of your baby
   ☐ hours the office or clinic was open
   ☐ understanding and respect the staff showed towards you as a person

MOTHER'S HEALTH

1. What month did you start prenatal care with this pregnancy? _____________________
2. How many prenatal visits were you able to keep for this pregnancy? ______________
3. Have you had your six-week check-up (postpartum) after this pregnancy? ☐ YES ☐ NO
4. Previous Pregnancy:
   a. How many pregnancies have you had before this one?_______ How many living children?________
   b. How many stillbirths (fetal deaths)?_____ miscarriages?______ abortions?______
   c. Have any of your children had a birth defect? ☐ NO ☐ YES
      If yes, please explain____
      ____
   d. Did you have any complications with any previous pregnancy? ☐ NO ☐ YES
      If yes, please explain____
      ____
5. Family Planning:
   a. Were you using birth control when you became pregnant with this child? ☐ YES ☐ NO
   b. What are you currently using for birth control?____
   c. Do you need additional information on birth control methods? ☐ YES ☐ NO
6. Dental Health:
   a. Do you currently have a dentist? ☐ YES ☐ NO
   b. When was the last time you saw a dentist? ________________________
   c. Do you currently have any dental problems? ☐ NO ☐ YES
   d. Do your children have any dental problems? ☐ NO ☐ YES

SMOKING

1. Do you currently smoke cigarettes? ☐ NO ☐ YES
   a. How many cigarettes do you smoke a day? ____________
   b. Have you cut down? ☐ YES ☐ NO
   c. Have you/are you seriously considering quitting? ☐ YES ☐ NO
2. Have you ever smoked? ☐ NO ☐ YES
   a. When did you stop smoking? _____________
3. Do you plan to stay a non-smoker after this pregnancy ☐ YES ☐ NO
4. Has your smoking pattern changed since having the baby? ☐ NO ☐ YES
   If yes, please explain____

IMMUNIZATIONS

1. Have you been immunized against any of the following infections?
   ☐ Chicken Pox ☐ Hepatitis B ☐ Measles ☐ Meningitis ☐ Mumps ☐ Rubella ☐ Don't Know
2. Have you ever been around anyone with these infections in the last month? ☐ NO ☐ YES

Infant's Name: ______________________

3. Are the immunization records on all preschool children in the household available? ☐ YES ☐ NO
4. What immunizations has your new baby received? ______________________
5. What questions do you have about immunizations? ______________________

INFANT'S NUTRITION

1. Infant current weight or at last doctor visit? ________ Current height/length? ________
2. Are you breastfeeding? ☐ YES ☐ NO
   If yes, what concerns do have about breast-feeding?______________________
3. Are you bottle feeding? ☐ YES ☐ NO
   If yes, describe how you mix your formula?______________________
   If yes, describe how you warm the bottle?______________________
4. Do you put cereal in the bottle? ☐ NO ☐ YES
   If yes, how much? ______________________
   If yes, how often? ______________________
5. Is your baby eating solid food? ☐ YES ☐ NO
6. Describe a typical day's feeding: ______________________
   ____
7. How many of the following does your baby have per day?
   a. Bowel movement ____________
   b. Wet diapers ____________
8. How many times a day does your baby spit up? ________ When and how much?______________________
9. What concerns do you have about the way your baby eats? ______________________
10. Do you have enough formula/food for a whole day? ______________________

MOTHER'S/ CAREGIVER'S NUTRITION

1. What changes, if any, have you made in your eating habits since the baby was born? ______________________
   ____
2. Have you ever had an eating disorder? ☐ NO ☐ YES
   If yes, please describe ______________________
3. Do you have enough food for yourself? ☐ YES ☐ NO
   a. For others in the household? ☐ YES ☐ NO
   b. Are you currently enrolled in WIC? ☐ YES ☐ NO
   c. Do you receive food stamps? ☐ YES ☐ NO
   d. What other resources do you have for food?______________________

EMOTIONAL/ MENTAL HEALTH INFORMATION

EMOTIONAL/ MENTAL STRESS

1. Are you a first-time parent? ☐ NO ☐ YES
   If yes, have you taken care of a baby before? ☐ NO ☐ YES
   If no, what are your concerns about being a parent? ______________________
2. How did you feel when you found out you were pregnant? ______________________
3. How does your partner feel about this baby? ______________________
4. Is your partner the father of the baby? ☐ YES ☐ NO
   a. If no, what is your current relationship with the father of the baby? ______________________
   ____
5. Who can you depend on when you need help or someone to talk to? ______________________
   a. Will you be relying on them for assistance with child care? ☐ NO ☐ YES
   b. What agencies are helping you with the care of your baby? ______________________
6. Have you or a family member been involved with Children's Protective Services (CPS)? ☐ NO ☐ YES
7. Are you feeling particularly stressed right now? ☐ NO ☐ YES
   If yes, please describe. ______________________
8. How do you normally cope with stress? ______________________
9. What are you family strengths right now? ______________________
   ____
10. Depression
    a. Have you had any of these feelings since your baby was born?
       ☐ Depressed mood ☐ Loss of interest in usually pleasurable activities ☐ Difficulty concentrating or making decisions
       ☐ Fatigue ☐ Changes in appetite or sleep ☐ Recurrent thoughts of suicide ☐ Feelings of worthlessness or guilt
       ☐ Excessive anxiety
    b. Have you ever been diagnosed with a mental illness by a health professional? ☐ NO ☐ YES
       If yes, are you currently taking medications for this illness? ☐ NO ☐ YES
       If yes, are you currently seeing a mental health counselor? ☐ NO ☐ YES
11. Domestic Violence – Since the baby was born:

a. Has your partner pushed, hit, slapped, kicked, choked or physically hurt you in any way? ☐ NO ☐ YES
b. Has anyone else physically hurt you in any way? ☐ NO ☐ YES
c. Are you fearful of your safety at this time? ☐ NO ☐ YES

12. Parenting –
   a. Child Interaction Assessment (Complete this information from observation)
      ☐ Baby is easy to console
      ☐ Speaks endearingly to baby
      ☐ Has pleasurable time with feeding
      ☐ Seems confident about care giving
      ☐ Touches baby frequently
      ☐ Has eye contact with baby while holding
      ☐ Smiles at baby frequently
      ☐ Responds to baby's needs (in tune with baby)
      ☐ Prepared at home for baby
      ☐ Have realistic expectations of baby
   b. When your baby is upset, what do you do to quiet him or her? ___________________________________
   c. What questions do you have about taking care of your baby? ___________________________________

13. Growth and Development
   a. Which of these developmental milestones have you seen in your baby?
      ☐ Follows your face and eyes
      ☐ Sleeps for 3-4 hours at a time
      ☐ Good head control
      ☐ Rolls over
      ☐ Crawls
      ☐ Picks up with two fingers
      ☐ Recognizes your voice
      ☐ Coos or vocalizes
      ☐ Raises body on hands
      ☐ Shakes an object
      ☐ Walks
      ☐ Holds cup
      ☐ Lifts head when on stomach
      ☐ Smiles
      ☐ Sits with support
      ☐ Pulls to stand
      ☐ Plays peek-a-boo
      ☐ Feeds self

ENVIRONMENTAL INFORMATION

1. What is your current housing situation? (Select all that apply.)
   ☐ House-own ☐ Apartment ☐ Live with FOB ☐ Shelter ☐ Friend
   ☐ House-rent ☐ Live with SO (not fob) ☐ Migrant Housing ☐ Relative ☐ Rent
   ☐ Live with parents ☐ Homeless ☐ Other
2. Is your current housing?
   ☐ Built before 1950 ☐ Remodeled/renovated in the last year ☐ Near an industrial plant, dump site
3. Does your house (or frequently visited home) have peeling or chipping paint? ☐ NO ☐ YES
4. Does your house (or frequently visited home) have a lot of dust and mold? ☐ NO ☐ YES
5. Was asbestos insulation used on pipes or hot water tank or for insulation in attic/walls? ☐ NO ☐ YES
6. Does anyone in your household work around lead (pottery, automobile repair, plumbing)? ☐ NO ☐ YES
7. Do you regularly (at least weekly) use cleaners for glass, oven, floors, glues, solvents, paint strippers? ☐ NO ☐ YES
8. Do you currently use pesticides (bug or weed killer, flea or tick spray) in the home? ☐ NO ☐ YES
9. What is the source of your drinking water? ☐ well ☐ city ☐ store bought
10. Are the following in good working order? ☐ furnace ☐ plumbing ☐ refrigerator ☐ stove
11 Do you have a working smoke detector? ☐ YES ☐ NO
   Last time checked?________________________________
12. Does anyone in your household:
   a. Smoke? ☐ NO ☐ YES
   b. Use a wood stove? ☐ NO ☐ YES
13. Do you have guns and/or weapons in your home? ☐ NO ☐ YES
14. How many times have you moved in the past year? ________ Why? ____________________________
15. Are you having any housing problems at this time? ☐ NO ☐ YES
   If yes, please describe ____
16. Are you having problems paying bills at this time? ☐ NO ☐ YES
   If yes, ☐ rent/mortgage ☐ gas ☐ electric ☐ phone
   More description ____

Infant's Name: ______________________

17. Do your child/children have a car seat? ☐ YES ☐ NO
    If yes, is the car seat ☐new ☐ used
    a. Have you been shown how to install the seat in your vehicle? ☐ YES ☐ NO
18. Where does your new baby usually sleep?______________________
    a. How do you most often lay your baby down to sleep? ☐ Back ☐ Side ☐ Stomach
    b. How often does your new baby sleep in the same bed with you or anyone else? ______________________
    c. Do you have a crib for your baby? ☐ YES ☐ NO
19. Do you need help getting baby items? ☐ YES ☐ NO

PARENTING EDUCATION CLASSES

1. Have you ever attended a group parenting class? ☐ NO ☐ YES
2. Would like to attend a group parenting class? ☐ YES ☐ NO
3. Will there be a problem getting to the class? ☐ NO ☐ YES

KEEPING MEDICAL APPOINTMENTS (TRANSPORTATION)

1. How do you usually get to healthcare appointments (e.g., doctor's office, WIC, lab, pharmacy, etc.)? ______________________
2. Do you drive? ☐ YES ☐ NO
3. Do you have access to a reliable vehicle? ☐ YES ☐ NO
4. Do you have any concerns with keeping your baby's medical appointments? ______________________
5. If you know, what is the maximum distance you will have to travel to keep your appointments? ______________________
6. If you are in a Medicaid Health Plan, have they ever helped you to get to the doctor's office? ☐ YES ☐ NO

SUMMARY

CAREGIVER'S SUMMARY

1. Do you understand what the MIHP program is about? ☐ YES ☐ NO
2. What do you want the MIHP team to work with you on? ______________________
   ____
3. Do you foresee any problems keeping appointments with the MIHP team? ☐ NO ☐ YES
   What kind? ______________________
   ____

Infant's Name: ______________________

CLINICIAN ASSESSMENT SUMMARY

Strengths: ______________________

Weaknesses: ______________________

Referrals Made: ______________________

I have provided a copy of the following MIHP information:

- ☐ Caregiver grievance policy/procedure
- ☐ Medical and non-medical emergency options

MIHP assessment form completed by:

Signature	Discipline	Date