MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Bulletin Number: MSA 08-24

Distribution: Maternal Infant Health Programs, Local Health Departments, Medicaid Health Plans

Issued: June 1, 2008

Subject: Maternal Infant Health Program Consent Form (DCH-1190) and Prenatal Screener (MSA-1200)

Effective: July 1, 2008

Programs Affected: Maternal Infant Health Program

The purpose of this bulletin is to notify providers of revised Maternal Infant Health Program (MIHP) forms and procedures.

The Michigan Department of Community Health (MDCH) has revised the MIHP Consent Form (DCH-1190) to ensure compliance with HIPAA privacy regulations. The MIHP Prenatal Risk Factor Eligibility Screening Form (MSA-1200) has been renamed the Maternal Risk Identifier, and revised in response to recommendations from the Michigan Families Medicaid Project (MFMP) pilot sites. Copies of the forms are attached.

MSA-1200

Beginning July 1, 2008, the MSA-1200 will be available in both paper and electronic formats. All providers not meeting the exception criteria below will be required to utilize the electronic format. This format, which will be available online at https://sso.state.mi.us/, will populate a MDCH MIHP database. The data will begin to provide a profile of screened needs of the MIHP population.

Providers may input data directly into the electronic format during the screening process, or use the paper version of the form and input the data into the electronic format later. Data must be entered into the electronic format prior to billing for services.

The paper version of the MSA-1200 is available for download at www.michigan.gov/medicaidproviders >> Policy and Forms.

Exception Criteria

MIHP providers currently using the MDCH approved Michigan Maternal Infant Health Program Prenatal Risk Factor Eligibility Screening WIC Version may temporarily submit a paper copy of their screener for manual input to the database. Once an electronic integrated screener is developed, online usage will be required.

Exceptions to the online requirement for reasons other than use of the integrated screener will be considered on a case-by-case basis. Exception requests should be mailed to:

Jean Egan, MIHP Public Health Consultant
Michigan Department of Community Health
P.O. Box 30195
Lansing, MI 48909
eganj@michigan.gov

Providers exempt from using the electronic format will mail the completed screeners to the above address for manual entry into the database.

Training

MDCH MIHP staff provides a webcast training and access information related to the use of the MSA-1200 electronic format. For training information, refer to the June 29, 2007 memorandum from MDCH Division of Family and Community Health regarding MIHP Redesign - Next Steps Electronic Database (copy attached). Inquiries regarding the training can be addressed to Ingrid Davis at (517) 335-9546, or e-mail at Davisi1@michigan.gov.

Manual Maintenance

Retain this bulletin until the information has been incorporated into the Michigan Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Community Health, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approved

Paul Reinhart, Director
Medical Services Administration

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JENNIFER M. GRANHOLM
GOVERNOR

JANET OLSZEWSKI
DIRECTOR

MEMORANDUM

DATE: June 29, 2007

TO: Local Health Department Officers, MIHP Agency Chief Executive Officers, and MIHP Coordinators

FROM: Brenda Fink, A.C.S.W., Director
Division of Family and Community Health
Michigan Department of Community Health

SUBJECT: MIHP Redesign - Next Steps Electronic Database

As part of our continuing MIHP redesign, we have been working on the development of an electronic database that was identified as one of the key elements of the new program design. The objective is to accomplish improved information sharing between programs, where appropriate and with participant consent, and to improve our collective ability to evaluate program outcomes. We are now ready to take the first beginning steps toward these objectives. We have been regularly updating our large stakeholder MIHP Implementation Workgroup about progress in this area, including the fact that the MIHP database is planned to have interface capability with the new WIC data system in 2008.

Our first step is to initiate an on-line electronic data entry process for the Prenatal Risk Factor Eligibility Screening Form (MSA 1200). Effective October 1, 2007, all MIHP Prenatal Risk Factor Eligibility Screening Form data will need to be electronically entered into the MDCH Medicaid MIHP database. Each agency will need to develop a process for efficiently entering data. Data entry can occur at the agency or at the beneficiary's home. Training for provider staff is planned as described below. Once staff is aware of how data is entered, it will be easier to determine how best to do this at each agency. Some process options will be discussed during the training.

This initial step is designed to work with basic computer and software requirements. Essentially internet access is the core requirement.

Minimum Hardware and Software Requirements:

Hardware
Computer or laptop with Windows 98 (or higher) operating system and Internet connectivity (dial up or high speed)

If you wish to use the system from remote locations, you'll need to investigate wireless connectivity in the form of an Internet Service Provider (ISP) - examples include SPRINT and Verizon. You will also need a laptop with Windows XP Operating system that meets the requirements of your chosen wireless ISP.

Software
Internet Explorer Version 6.0 or higher

MDCH will conduct a web cast orientation/training on September 14, 2007 from 9:00 a.m. to Noon. Registration materials will be sent to MIHP coordinators in the near future. We encourage all program coordinators and staff

to view the web cast. Your IT person may wish to participate as well. The web cast will be available for you to view after the training. You will receive information on this at a later date.

It is our intent to support this implementation process with state technical assistance, as well as through ongoing communication with each of you to identify and resolve issues that may occur. More detail about the mutual monitoring process will be shared in the near future, and we look forward to your input regarding implementation.

If your staff has questions or concerns, please contact Ingrid Davis at 517/335-9546 or email her at davisi1@michigan.gov. We look forward to partnering with you in this important next step in the MIHP redesign process.

cc: Jean Chabut
Alethia Carr
Gail Maurer
Mark Bertler
Nurse Administrators Forum
MALPH Administrators Forum

This form has been revised 6/20/08. Section 10 - Abuse/ Violence. at www.michigan.gov/medicaidproviders >> Policy and Forms.

Michigan Department of Community Health

Maternal Infant Health Program
Maternal Risk Identifier

1 BASICS/DEMOGRAPHICS

Medicaid ID Number:	Screening Date (MM/DD/YYYY) : / /

IDENTIFICATION

First Name	Middle Initial	Last Name

Social Security Number				What is your date of birth? (MM/DD/YYYY)	/ / ☐ REFUSED

What do you identify as your race/ethnic background? (check all that apply, question is optional)

- ☐ Asian
- ☐ American Indian or Alaska Native
- ☐ Black or African American
- ☐ Hispanic/Latino
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White/Caucasian
- ☐ Arabic
- ☐ REFUSED

How many grades of school have you completed?

- ☐ Junior high/middle school = 8
- ☐ High school diploma/GED = 12
- ☐ REFUSED
- ☐ Associate's degree = 14
- ☐ Bachelor's degree = 16

	YES	NO		
Do you currently work outside the home?	☐	☐	If YES, how many hours do you work in a typical week?	Hours
Are you currently attending school?	☐	☐	Are you currently married or unmarried? ☐ Married ☐ Unmarried ☐ REFUSED	

2 HEALTH HISTORY/RISKS

When was your last menstrual period? (MM/DD/YYYY) / / ☐ DON'T KNOW ☐ REFUSED

When is your baby due? (MM/DD/YYYY) / / ☐ DON'T KNOW ☐ REFUSED

How do you feel about becoming pregnant? Did you . . .

- ☐ Want to be pregnant sooner
- ☐ * Want to be pregnant later
- ☐ Want to be pregnant now
- ☐ REFUSED
- ☐ * Not want to be pregnant now or any time in the future
- ☐ DON'T KNOW

At the time you became pregnant were you using any birth control method?

☐ YES ☐ NO ☐ DON'T KNOW ☐ REFUSED

What was your weight just before you became pregnant this time? Pounds ☐ DON'T KNOW ☐ REFUSED

What is your height without shoes? Feet ____ Inches ____ ☐ REFUSED

Including this pregnancy, how many times have you been pregnant? *(Count any abortions, miscarriages or stillbirths)*

☐ 1 Time (First Pregnancy) ____ Times ☐ REFUSED

When did your last pregnancy end? (date of last delivery, abortion, miscarriage or stillbirth**)** MM YYYY ____/____ ☐ REFUSED

(Approximate if necessary)

Did any of your previous pregnancies result in:	Yes	Pregnancy #	No
* Miscarriage in the 4th month of pregnancy or later?			
* Stillbirth?			
* Baby weighing less than 5.5 pounds at birth?			
* Baby born more than 3 weeks early (or did anyone tell you that your baby was premature/preterm?)			
* Baby that stayed in the hospital after you went home?			

☐ REFUSED

Have you ever been treated for or told that you have:

High blood pressure (hypertension)? ☐ Yes ☐ No (If No, go to next box.)
When did you last see a health care provider about this problem? MM/YYYY
Do you have another visit scheduled? ☐ Yes ☐ No
Have you been in the hospital or ER for this problem in the last six months? ☐ Yes ☐ No
Comments:

Anemia or sickle cell disease? ☐ Yes ☐ No (If No, go to next box).
Have you ever had a blood transfusion for this problem? ☐ Yes ☐ No Last Date MM/YYYY
When did you last see a health care provider about this problem? MM/YYYY
Do you have another visit scheduled? ☐ Yes ☐ No
Have you been in the hospital or ER for this problem in the last six months? ☐ Yes ☐ No
Comments:

Diabetes or high blood sugar? ☐ *Yes ☐ No (If No, go to next box.)
Is it Insulin dependent? ☐ Yes ☐ No
When did you last see a health care provider about this problem? MM/YYYY
Do you have another visit scheduled? ☐ Yes ☐ No
Have you been in the hospital or ER for this problem in the last six months? ☐ Yes ☐ No
Comments:

Asthma? ☐ Yes ☐ No (If No, go to next box.)
When did you last see a health care provider about this problem? MM/YYYY
Do you have another visit scheduled? ☐ Yes ☐ No
Have you been in the hospital or ER for this problem in the last six months? ☐ Yes ☐ No

Have you ever been treated for or told that you have:

Comments:

Problems with your heart, kidneys, or lungs? ☐ Yes ☐ No (If No, go to next box.)

When did you last see a health care provider about this problem? MM/YYYY

Do you have another visit scheduled? ☐ Yes ☐ No

Have you been in the hospital or ER for this problem in the last six months? ☐ Yes ☐ No

Comments:

Problems with bleeding? ☐ Yes ☐ No (If No, go to next box.)

When did you last see a health care provider about this problem? MM/YYYY

Do you have another visit scheduled? ☐ Yes ☐ No

Have you been in the hospital or ER for this problem in the last six months? ☐ Yes ☐ No

Comments:

Recurring vaginal infections? ☐ Yes ☐ No (If No, go to next box.)

When did you last see a health care provider about this problem? MM/YYYY

Do you have another visit scheduled? ☐ Yes ☐ No

Have you been in the hospital or ER for this problem in the last six months? ☐ Yes ☐ No

Comments:

A sexually transmitted infection? ☐ Yes ☐ No (If No, go to next box.)

When did you last see a health care provider about this problem? MM/YYYY

Do you have another visit scheduled? ☐ Yes ☐ No

Have you been in the hospital or ER for this problem in the last six months? ☐ Yes ☐ No

Comments:

Other problems that you see a doctor for? ☐ Yes ☐ No (If No, go to next box.)

If Yes, Explain: _____

When did you last see a health care provider about this problem? MM/YYYY

Do you have another visit scheduled? ☐ Yes ☐ No

Have you been in the hospital or ER for this problem in the last six months? ☐ Yes ☐ No

Comments:

Are you now taking any prescription drugs? ☐ Yes ☐ No (If No, go to next box.) ☐ REFUSED

Which prescription drugs are you taking?

How long has it been since you had a dental exam and cleaning?

☐ Within the past year
☐ Within the past 2 years
☐ Within the past 5 years
☐ DON'T KNOW /NOT SURE
☐ Never
☐ REFUSED

☐ More than 5 years ago

In the past year, have you noticed any problems with your teeth or gums such as bad breath that won't go away, loose or sensitive teeth, or gums that are red, swollen, tender, or bleeding? ☐ Yes ☐ No

3 PRENATAL CARE

When you have a health issue or problem, where do you usually go for care?

☐ Doctor's office
☐ Public health clinic
☐ Readicare facility
☐ Hospital
☐ Emergency Room
☐ Other: _____
☐ Nowhere
☐ REFUSED

How many months pregnant were you when you had your first visit for prenatal care? Do not count a visit that was only for a pregnancy test or only for WIC.

_____ Months ☐ I haven't gone for prenatal care ☐ REFUSED

Have you had any trouble getting the prenatal care you want or need? ☐ *Yes ☐ No
☐ REFUSED

Here is a list of problems some women can have getting prenatal care. For each item, please let us know if it has been true for you at any time during this pregnancy [READ LIST]

☐ I couldn't get an appointment when I wanted one
☐ I couldn't find a doctor or clinic that accepted Medicaid
☐ It is hard to communicate with the doctor or clinic staff
☐ It is hard to understand the information the doctor or clinic gives to me
☐ I haven't had enough money or insurance to pay for my visits
☐ I haven't had my Medicaid card or Guarantee of Payment letter
☐ * I've had no way to get to the clinic or doctor's office
☐ I couldn't take time off from work
☐ I've had no one to take care of my children
☐ I have had too many other things going on in my life
☐ *I didn't want anyone to know I was pregnant
☐ Other. Please tell us: _____
☐ REFUSED

4 SMOKING

Which of the following statements would you say best describes your cigarette smoking? Would you say:

☐ *I smoke regularly now – about the same amount as before finding out I was pregnant

☐ *I smoke regularly now, but I've cut down since I found out I was pregnant

☐ *I smoke every once in a while

☐ I have quit smoking since finding out I was pregnant

☐ I wasn't smoking around the time I found out I was pregnant, and I don't currently smoke cigarettes. (If checked, go to next section.)

☐ REFUSED

How many cigarettes do you smoke on an average day now/or did you before quitting?

☐ 1-1/2 or more packs
☐ 1 to 1-1/2 packs
☐ 1/2 to 1 pack
☐ REFUSED
☐ 6 to 10 cigarettes
☐ 1 to 5 cigarettes
☐ Less than 1 cigarette

How soon after you wake up do you smoke your first cigarette?

☐ Within 5 minutes ☐ 6-30 minutes ☐ 31 or more minutes

Do you find it difficult to stop smoking in non-smoking areas? ☐ Yes ☐ No

Which cigarette would you MOST hate to give up? ☐ The first cigarette in the morning ☐ All others

Do you smoke MORE FREQUENTLY in the first hours after waking than the rest of the day? ☐ Yes ☐ No

Do you smoke if you are so ill that you are in bed most of the day? ☐ Yes ☐ No

If still smoking:

Have you seriously thought about quitting smoking during this pregnancy? ☐ Yes ☐ No
Have you tried to quit smoking in the last 30 days? ☐ Yes ☐ No
Have you made any changes or gotten any supports to make it easier for you to not smoke? ☐ Yes ☐ No

5 ALCOHOL

Which of the following statements would you say best describes your alcohol consumption, INCLUDING beer and wine coolers? Would you say:

☐ *I drink alcohol regularly now – about the same amount as before finding out I was pregnant
☐ *I drink alcohol regularly now, but I've cut down since I found out I was pregnant
☐ *I drink alcohol every once in a while
☐ I have quit drinking alcohol since finding out I was pregnant
☐ I wasn't drinking alcohol around the time I found out I was pregnant, and I don't currently drink. (If checked, go to next section.)
☐ REFUSED

Approximately how many alcoholic drinks do you have in an average week/or did when drinking?

☐ 14 drinks or more a week
☐ 7 to 13 drinks a week
☐ 4 to 6 drinks a week
☐ 1 to 3 drinks a week
☐ Less than 1 drink a week
☐ REFUSED

How many drinks does it/did it take to make you feel the high? ☐ 1 ☐ 2 ☐ 3 or more ☐ REFUSED

Have people annoyed you by criticizing your drinking? ☐ Yes ☐ No ☐ REFUSED

Have you ever felt you ought to cut down on your drinking? ☐ Yes ☐ No ☐ REFUSED

Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?
☐ Yes ☐ No ☐ REFUSED

If still drinking alcohol:

Have you seriously thought about quitting all alcohol during this pregnancy? ☐ Yes ☐ No ☐ REFUSED
Have you tried to quit drinking alcohol in the last 30 days? ☐ Yes ☐ No ☐ REFUSED
Have you made any changes or gotten any supports to make it easier for you to not drink alcohol?
☐ Yes ☐ No ☐ REFUSED

6 DRUG USE

Does your partner or anyone in your household use street drugs? ☐ *Yes ☐ No ☐ REFUSED

In the month before you knew you were pregnant, did you use any street drugs, diet pills, or drugs not prescribed by a physician? ☐ *Yes ☐ No (If checked, go to next section.) ☐ REFUSED

What did you use? (check all that apply)

- ☐ Marijuana
- ☐ Crack
- ☐ Heroin
- ☐ Downers
- ☐ Diet Pills
- ☐ Other:
- ☐ PCP
- ☐ Cocaine
- ☐ Uppers/Crank/Meth/Speed
- ☐ LSD
- ☐ Prescription drugs not prescribed for you

What drugs have you used since becoming pregnant? (check all that apply)

- ☐ Marijuana
- ☐ Crack
- ☐ Heroin
- ☐ Downers
- ☐ Diet Pills
- ☐ Other:
- ☐ PCP
- ☐ Cocaine
- ☐ Uppers/Crank/Meth/Speed
- ☐ LSD
- ☐ Prescription drugs not prescribed for you
- ☐ None

If still using drugs:

Have you seriously thought about quitting all drugs during this pregnancy? ☐ Yes ☐ No
Have you tried to quit using drugs in the last 30 days? ☐ Yes ☐ No
Have you made any changes or gotten any supports to make it easier for you to not use drugs? ☐ Yes ☐ No

7 STRESS

In the last month, how often have you felt that you were unable to control the important things in your life?
☐ Never ☐ Almost never ☐ *Sometimes ☐ *Fairly often ☐ *Very often

In the last month, how often have you felt confident about your ability to handle your personal problems?
☐ * Never ☐ *Almost never ☐ *Sometimes ☐ Fairly often ☐ Very often

In the last month, how often have you felt that things were going your way?
☐ * Never ☐ *Almost never ☐ *Sometimes ☐ Fairly often ☐ Very often

In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?
☐ Never ☐ Almost never ☐ *Sometimes ☐ *Fairly often ☐ *Very often

8 DEPRESSION AND MENTAL HEALTH

Have you ever been treated for or told that you have depression, bipolar disorder, anxiety, schizophrenia or any other mental health problem? ☐ *Yes ☐ No
When did you last see a health care provider about this problem? MM/YYYY
Do you have another visit scheduled? ☐ Yes ☐ No
Have you been in the hospital or ER for this condition in the last six months? ☐ Yes ☐ No

DEPRESSION FOLLOW-UP SCREENING

I'd like to ask you some follow-up questions about how you're feeling. I'm going to read you some statements and responses. For each statement, please let me know which response is closest to how you've been in the past 7 days.

I have been able to laugh and see the funny side of things
☐ As much as I always could
☐ Not quite so much now
☐ Definitely not so much now
☐ Not at all

I have looked forward with enjoyment to things
☐ As much as I ever did
☐ Rather less than I used to
☐ Definitely less than I used to
☐ Hardly at all

I have blamed myself unnecessarily when things went wrong
☐ Yes, most of the time
☐ Yes, some of the time
☐ Not very often
☐ No, never

I have been anxious or worried for no good reason
☐ No, not at all
☐ Hardly ever
☐ Yes, sometimes
☐ Yes, very often

I have felt scared or panicky for no very good reason
☐ Yes, quite a lot
☐ Yes, sometimes
☐ No, not much
☐ No, not at all

Things have been getting the best of me
☐ Yes, most of the time I haven't been able to cope at all
☐ Yes, sometimes I haven't been coping as well as usual
☐ No, most of the time I have coped quite well
☐ No, I have been coping as well as ever

I have been so unhappy that I have had difficulty sleeping
☐ Yes, most of the time
☐ Yes, sometimes
☐ Not very often
☐ No, not at all

I have felt sad or miserable
☐ Yes, most of the time
☐ Yes, quite often
☐ Not very often
☐ No, not at all

I have been so unhappy that I have been crying

- ☐ Yes, most of the time
- ☐ Yes, quite often
- ☐ Only occasionally
- ☐ No, never

The thought of harming myself has occurred to me

- ☐ Yes, quite often
- ☐ Sometimes
- ☐ Hardly ever
- ☐ Never

9 SOCIAL SUPPORT

Would you describe the father of this baby as:

- ☐ Involved in my pregnancy and supportive of me
- ☐ Involved but not supportive of me
- ☐ *Aware that I'm pregnant but not involved
- ☐ Not aware that I'm pregnant
- ☐ REFUSED

Is there someone in your life who you can count on to help you during this pregnancy and with your new baby?

☐ Yes ☐ *No

Who do you count on for support? (check all that apply)

- ☐ Partner and/or the baby's father
- ☐ Parent(s)
- ☐ Other child or children
- ☐ Other relative(s)
- ☐ Friend(s)/Neighbor(s)
- ☐ Clergy and/or people at my place of worship
- ☐ Other: _____

10 ABUSE/VIOLENCE

Do you feel safe in your present relationship? ☐ I am not in a relationship right now ☐ Yes ☐ *No

Within the last year, have you been hit, kicked, slapped, or otherwise physically hurt by someone? ☐ *Yes ☐ No

By whom? (Check all that apply) ☐ Current partner ☐ Ex-partner ☐ Stranger ☐ Others

Specify _____

How many times has this happened? _____ times

Since you have been pregnant, have you been hit, slapped, kicked or otherwise physically hurt by someone?

☐ *Yes ☐ No

By whom? (Check all that apply) ☐ Current partner ☐ Ex-partner ☐ Stranger ☐ Others

Specify _____

How many times has this happened? _____ times

What part or parts of your body were hurt? ☐ Limbs ☐ Torso ☐ Head

How did this person hurt you? (Score the most severe incident to the following scale)

- ☐ Threats of abuse, including use of a weapon
- ☐ Slapping, pushing; no injuries and/or lasting pain
- ☐ Punching, kicking, bruises, cuts and/or continuing pain
- ☐ Beaten up, severe contusions, burns, broken bones
- ☐ Head, internal, and/or permanent injury
- ☐ Use of weapon, wound from weapon

Has your partner or someone else now in your life:

- ☐ *Called you names, humiliated you, or made you feel that you don't count?
- ☐ *Kept you from seeing or talking to your family, friends, or other people?
- ☐ *Thrown away or destroyed your belongings, threatened pets, or done other things to bully or scare you?
- ☐ *Controlled your use of money, your access to money or your ability to work?

Within the past year, has anyone forced you to have sexual activities? ☐ *Yes ☐ No

Who was it? (Check all that apply) ☐ Current partner ☐ Ex-partner ☐ Stranger ☐ Others

Specify _____

How many times has this happened? _____ times

Have you ever been emotionally or physically abused by your partner or someone important to you? ☐ *Yes ☐ No

Are you afraid of your partner or anyone you listed above? ☐ *Yes ☐ No

11 BASIC NEEDS

In the last 12 months, did you (or other adults in your household) ever cut the size of your meals or skip meals because there wasn't enough money for food? ☐ Yes ☐ No

How often did this happen? ☐ Almost every month ☐ Some months but not every month

☐ In only 1 or 2 months

How many times have you moved in the past 12 months? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

Do you currently have any concerns or worries about your housing situation? ☐ *Yes ☐ No

What are your concerns or worries about your housing? (check all that apply)

Instability

- ☐ No place to live, no regular nighttime residence
- ☐ Eviction or being forced to move out
- ☐ Affordability of current house or apartment
- ☐ Strained relations with others in household

Adequacy

- ☐ House or apartment is too crowded
- ☐ Lack of continuous functioning basic utility service (e.g., heat, electricity)

Safety

- ☐ Safety of house/apartment
- ☐ Safety of neighborhood

How often do you have access to a telephone to make and receive calls where you live?

☐ Always ☐ Sometimes ☐ Never

12 BREASTFEEDING

Which of the following best describes your thoughts on breastfeeding your new baby?

- ☐ I know I will breastfeed
- ☐ I think I might breastfeed
- ☐ REFUSED
- ☐ I know I will not breastfeed
- ☐ I don't know what to do about breastfeeding

CERTIFICATION

Throughout this identification tool form an asterisk (*) was placed next to the responses that if checked by the beneficiary would indicate they have a risk. If a beneficiary checks, at a minimum, one box where the corresponding response has an asterisk, they are automatically eligible for Maternal Infant Health Program (MIHP). In the event none of the beneficiary's answers on this form are marked by an asterisk, they may still be assessed based on the MIHP provider's judgment. Under these circumstances, MIHP providers must clearly document the need for services in the beneficiary's record.

The MSA-1200 must be used by Medicaid enrolled Maternal Infant Health Program providers. The form must be completed and entered into the electronic format prior to billing Medicaid. Fill in enabled copies of this form can be

downloaded from the MDCH website www.michigan.gov/medicaidproviders >>Policy and Forms. The form is generally self-explanatory. Completion of the form is mandatory.

Screener Comments:

MIHP Maternal Risk Identifier Form completed by:

Name:		Discipline	
Date:	MM/DD/YYYY	Location of visit:	

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

MATERNAL INFANT HEALTH PROGRAM

Authorization and Consent to Release Protected Health Information

The Michigan Department of Community Health, **Maternal Infant Health Program (MIHP)** is designed to provide you with information and referrals to agencies that may help you and your baby stay healthy and assist you with caring for yourself and your infant. To do this, **we would like you to answer some questions to help us understand** your daily living habits and to identify potential health risks to you and your infant.

The answers that you give to the questions are protected health information and will be kept confidential unless we are permitted or required by law to release them. In order to plan and provide the best possible care for you and your infant, we may need to share the answers that you give with various health and social services professionals and other community agencies. To assure that MIHP services are coordinated with your primary health care provider, we may also need to provide information regarding services you receive or need with your physician.

Your answers to the questions in this interview will assist MIHP staff to determine what, if any, services are appropriate for you. You may choose to not answer some questions or end the interview at any time and this will not affect your Medicaid eligibility. However, lack of information resulting from these actions may result in you not receiving services that might otherwise be available through this program.

- By signing this form, I authorize the (name of the MIHP agency) to disclose my health information.
- I understand that this information may include, when applicable, information relating to sexually transmitted diseases, Human Immunodeficiency Virus (HIV Infection, Acquired Immune Deficiency Syndrome or AIDS Related Complex) and other communicable diseases. It may also include information about behavioral or mental health services, and referral and/or treatment for alcohol and drug abuse (as permitted by MCL 330.1748, P.A. 258 of 1974 and 42 CFR Part 2).
- I also understand that if I give permission, I have the right to change my mind and revoke it. I understand that if I choose to revoke my permission, I will give written notice to the (MIHP agency) that maintains my records. I understand that any uses or disclosures already made with my permission cannot be taken back.
- I understand that authorizing the disclosure of this health information is voluntary. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my Medicaid eligibility for benefits unless the information is necessary to demonstrate that I meet eligibility or enrollment criteria.
- By signing this authorization, I understand that any disclosure of information carries with it potential for an unauthorized re-disclosure and the information may not be protected by federal privacy rules. I further understand I may request a copy of this signed Authorization.
- Unless otherwise revoked, this authorization will expire at the end of MIHP services.

I have read the above or have had it read/explained to me. I agree to allow health information disclosure.

_____	_____
Signature of Beneficiary or Legal Representative	Date

I understand that I may qualify to receive MIHP services.

- ☐ I **do not** wish to participate in the Maternal Infant Health Program.
- ☐ I **do** wish to participate in the Maternal Infant Health Program.

_____	_____
Beneficiary Name (Print)	Legal Representative and Relationship to Beneficiary
_____	_____
Signature of Beneficiary or Legal Representative	Date
_____	_____
Signature of Interviewer (MIHP staff)	Date

AUTHORITY: This form is acceptable to the Michigan Department of Community Health as compliant with HIPAA privacy regulations, 45CFR Parts 160 and 164 as modified August 14, 2002.
COMPLETION: Is Voluntary, but required if disclosure is requested.