MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Distribution: Maternal and Infant Support Services 03-01

Issued: April 1, 2003

Subject: Revised Chapter III

Effective: May 1, 2003

Programs Affected: Medicaid

The Department has revised the Maternal Support Services (MSS) and Infant Support Services (ISS) Chapter III. Chapter III contains policies, coverages, and billing instructions specific to MSS/ISS, and additional information relevant to these programs. The program policies have been revised to simplify and bring consistency in the way MSS/ISS services are provided. The changes are as follows:

- Changes to the written referral requirement
- Use of standard forms to complete assessments and other follow-up services
- Making case rate program available in counties under certain circumstances
- Changes in billing process due to implementation of Uniform Billing Project.

Manual Maintenance

Insert the attached Chapter III and Procedure Codes and Forms Appendices in your manual. Discard the current Chapter III, Appendices "I," "K," "L," and "M," and Maternal and Infant Support Services bulletin No.'s 95-01, 96-01, 97-01, 00-01, and 00-02. This bulletin may be discarded when the manual maintenance is completed.

To assure providers have a complete manual, the following is a comprehensive list of all documents that should be included in the MSS/ISS Manual.

Chapter I – General Description (All Provider 96-02)

Chapter II – Recipient Eligibility (All Provider 03-01)

Chapter III – Coverages and Limitations (Maternal and Infant Support Services 03-01)

Chapter IV – Billing and Reimbursement (MSA 02-08)

Procedure Codes Appendix

Forms Appendix

Appendix "J" Section 504 (8-10-82)

Other Insurance Chapter (7-1-96) AP 96-02

Sanctioned Providers List (May 2002) AP 02-03

Michigan's Eligibility Verification System

Explanation Codes Appendix (8-1-01) AP 01-08

Bulletins: All Provider 03-02, All Provider 02-06, All Provider 02-05, All Provider 02-04, All Provider 02-03, All Provider 01-10, MSS/ISS 01-01, All Provider 01-03, All Provider 01-02, All Provider 00-11, All Provider 00-10, All Provider 00-07, All Provider 00-04, All Provider 00-02, All Provider 00-01, All Provider 99-04, All Provider 99-03, All Provider 97-08, All Provider 97-03, All Provider 97-01, All Provider 96-06, All Provider 96-03.

Questions

Any questions regarding this bulletin should be directed to Provider Support, Department of Community Health, P.O. Box 30731, Lansing, Michigan 48909-8231 or e-mail 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.

Approval

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PROGRAM PHILOSOPHY

The purpose of Maternal and Infant Support Services is to reduce infant mortality and morbidity. This is an objective of both the State of Michigan and the federal government that fund these programs. The goal of Maternal Support Services (MSS) is to alleviate social and psychosocial problems, health education deficits and transportation needs for medical appointments, and to aim for a delivery of a healthy baby at full term. The goal of Infant Support Services (ISS) is to work with the parent/caregiver of a high-risk infant to help the baby to stay healthy, obtain appropriate well baby visits, medical care, immunizations and link families with community agencies.

Accordingly, MSS are intended to help those pregnant Medicaid beneficiaries most likely to experience serious health problems due to psychosocial or nutritional problems. Both MSS and ISS are intended to supplement regular prenatal/infant care and to assist the following providers in managing the beneficiary's health and well-being:

- Physicians
- Certified nurse-midwives
- Pediatric nurse practitioners*
- Family nurse practitioners*

(*enrolled in the Medicaid Program per Michigan Department of Community Health (MDCH) guidelines)

DURATION OF COVERAGE

Maternal Support Services:

Pregnant women on Medicaid may qualify for MSS at any time during the pregnancy. The pregnant woman is the focus of these services. After delivery, a new MSS case cannot be opened. For purposes of case closing, services may be provided for up to 60 days after the pregnancy ends or the end of the month in which the 60th day falls. Some services to pregnant women after they have delivered are available through the Medicaid Home Health Program. Support services are available through Infant Support Services to moms of infants that meet the risk criteria.

Infant Support Services:

Coverage for ISS may begin as early as the infant's birth. ISS services are directed exclusively for the benefit of the infant on Medicaid, primarily by working with the infant's family.

The focus of both MSS and ISS is the family. MSS and ISS encompass essentially the same services. Services are generally provided to the same individual (pregnant woman/mother). In some situations, both of these services may need to be blended and provided since it is possible that families will meet the qualifying criteria for both MSS and ISS at the same point in time. In these situations, the provider **must** be certain to bill for **either** MSS professional services **or** ISS professional services, but not for both services when one professional intervention, albeit a "blended one", occurs with the family. As an exception, transportation services may be billed under MSS for the pregnant woman and under ISS for the infant.

It is the responsibility of the MSS/ISS provider to target these services to Medicaid beneficiaries most in need of this assistance.

PROGRAM SERVICES

Maternal Support Services (MSS) and Infant Support Services (ISS) are preventive health services that are delivered by an agency, which must be certified by the Michigan Department of Community Health, Health Programs Administration, Bureau of Children and Family Programs, Division of Family and Community Health. MSS and ISS services include:

- Psychosocial and nutritional assessment;
- Plan of care development;
- Professional intervention services of a multidisciplinary team consisting of a qualified
  - Social worker,
  - Nutritionist,
  - Nurse, and
  - Infant mental health specialist (if available)
- Arranging transportation **as needed** for health, substance abuse treatment, support services, and/or pregnancy-related appointments;
- Referral to community services, e.g. mental health, substance abuse;
- Coordination with medical care providers; and
- Childbirth classes or parenting education classes.

Program services consist of social work, nutrition, nursing services (including health education), counseling/social casework, and beneficiary advocacy services.

Infant mental health specialists should be involved with ISS cases, if at all possible and available in the geographic area. If not available, the provider must consider carefully how to provide this service.

RISK CRITERIA

Maternal Support Services:

MSS referrals are encouraged given the presence of any of the following conditions, which are likely to adversely affect the pregnancy:

- Homeless or dangerous living/home situation;
- Negative or ambivalent feelings about the pregnancy;
- Mother under age 18 **and** has no family support;
- Need for assistance to care for herself and infant;
- Mother with cognitive, emotional or mental impairment;
- Nutrition problem;
- Abuse of alcohol or drugs or smoking;
- Need for transportation to keep medical appointments; and/or
- Need for childbirth education classes.

Only those pregnant women that meet the above risk criteria should be enrolled in MSS. Medicaid eligibility by itself is not a qualifying condition for enrollment in MSS.

Infant Support Services:

ISS referrals are encouraged given the presence of any one of the following conditions existing with the mother or infant:

- Abuse of alcohol or drugs (especially use of cocaine), or smoking;
- Mother is under the age of eighteen (18) **and** has no family support;
- Family history of child abuse/neglect;
- Failure to thrive;
- Low birth weight (less than 2500 grams);
- Mother with cognitive, emotional or mental impairment;
- Homeless or dangerous living/home situation; and/or
- Any other condition that may place the infant at risk for death, illness or significant impairment when indicated by a physician.

RISK SCREENING

To identify high-risk beneficiaries for MSS/ISS services, a risk screening form must be completed to determine eligibility. The medical care provider (physician, certified nurse-midwife, Medicaid-enrolled pediatric or family nurse practitioner) or a MSS/ISS provider may complete and sign a MSS and/or ISS risk screening form to determine the eligibility for these programs. The form must indicate briefly the reason, i.e., problem(s), for which the beneficiary needs the services. If the risk screening form is completed by someone other than the medical care provider or MSS/ISS clinical staff, it must be signed and dated by the person completing the form. If a MSS case becomes an ISS case, the ISS risk screening form identifying the risk factors must be completed, signed and dated.

MEDICAID HEALTH PLANS

Medicaid Health Plans must ensure their enrollees have access to MSS/ISS. Medicaid Health Plans may opt to be certified and enroll as a MSS/ISS provider **or** make the MSS/ISS services available through a subcontract with a certified MSS/ISS provider. Similarly, the Special Health Plans must ensure access to MSS/ISS services to the dual eligible (Children's Special Health Care Services/CSHCS and Medicaid) beneficiaries enrolled in their Health Plan.

REIMBURSEMENT

The Department will reimburse MSS/ISS providers directly for services provided to beneficiaries enrolled in the Medicaid Fee For Service program. Medicaid Health Plans have the responsibility to reimburse for services provided to beneficiaries enrolled with the health plan.

The MSS/ISS provider must have a signed, written referral on file prior to billing for services. A medical care provider (physician, certified nurse-midwife, Medicaid-enrolled pediatric or family nurse practitioner) or MSS/ISS clinical staff are authorized to sign referrals for services. When billing for MSS/ISS services, providers must use the procedure codes listed in the Procedure Code Appendix.

PSYCHOSOCIAL/ NUTRITIONAL ASSESSMENT

After completion (or receipt) of the risk screening form, the MSS and/or ISS provider must complete a structured psychosocial/nutritional assessment to determine the scope of the beneficiary's needs for MSS or ISS services. The purpose of the assessment is to validate that the beneficiary meets the prerequisite risk criteria and to determine whether MSS or ISS services are **needed**. If the assessment does not indicate the need for MSS and ISS services, then no follow-up MSS and ISS service is to be provided. If a need is indicated, then an appropriate plan of care is to be developed clearly outlining the beneficiary's risk(s) and the intervention(s) to address the risk(s). If an MSS case subsequently becomes an ISS case, an additional risk assessment must be done to determine eligibility for ISS (mother and infant activity).

The beneficiary must be assessed for transportation needs, childbirth education/parenting education classes, health education needs, and family planning services. The assessment must precede, or coincide with, any professional visits. Only one assessment per beneficiary under MSS and only one assessment per beneficiary under ISS is covered. Due to factors such as premature termination of a pregnancy or a subsequent pregnancy in the same year, a beneficiary may be assessed and/or receive MSS/ISS services twice in the same year. In such instances, the provider must indicate "second pregnancy" in the remarks section of the claim.

The MSS/ISS interdisciplinary team/member does the assessment. All three professionals (i.e., the nurse, nutritionist, social worker) must be involved in the psychosocial/nutritional assessment – either directly or through a review/approval process.

No assessment is required if the beneficiary only needs a childbirth education or a parenting education class.

An assessment is required for pregnant women who need transportation for keeping medical appointments.

PLAN OF CARE

Based on the assessment, the interdisciplinary team develops a comprehensive plan of care to provide needed services to the beneficiary and/or referrals to community agencies. The plan of care must indicate the specific risk(s), specific outcome goal(s) and specific intervention(s) to be implemented and the number of visits required for actualizing the plan. The plan of care must be updated whenever a significant change occurs and must justify the interventions that are occurring. Follow-up services must be provided by the nurse, social worker and/or nutritionist based on the plan of care. While the provider has responsibility for determining how best to involve staff in carrying out the plan of care, it is expected that all professional staff will be used with most cases. It is not expected that one professional discipline will carry out most case interventions on a solo basis. The beneficiary's exit from the program is expected to occur when the objectives of the plan of care are completed, or when the team concludes that continued intervention would not be helpful.

CARE COORDINATION

For each beneficiary, a Care Coordinator (a member of the interdisciplinary team) must be assigned to monitor and coordinate all the MSS or ISS care, referrals, and follow-up services. It is the responsibility of the Care Coordinator for the individual case to be certain that families are appropriately followed and referred for needed services. The name of the Care Coordinator must be documented in the beneficiary's record.

ISS providers are encouraged to participate in local Children's Protective Services (CPS) Interdisciplinary Team meetings, Part C/Early On Interagency Coordinating Council meetings, and in similar efforts to coordinate the infant's care. The purpose of this activity is to ensure the use of and coordination with other community resources and to ensure ongoing support when the MSS and/or ISS case is closed.

When appropriate, MSS/ISS referrals to CPS workers must be made.

PROFESSIONAL VISITS

A professional visit/intervention is a face-to-face encounter with a beneficiary conducted by one or more certified professionals (i.e., social worker, nutritionist, or nurse) for the specific purpose of implementing the beneficiary's plan of care.

Professional visits **cannot** be billed for services provided to a group of beneficiaries.

The visit must extend **at least 30 minutes** in duration to be billable.

More than one visit may be provided on the same date of service provided a different professional does the second visit. The provider must keep in mind the capability of the beneficiary to benefit from extended counseling/education when two visits are provided on the same day.

Visits should be used judiciously since there is a limit on the number of visits that will be reimbursed. The beneficiary must not be billed for additional visits provided.

The professional visit fee includes Medicaid reimbursement for related care coordination and monitoring activities.

All professional visits, including the place of service, must be documented in the beneficiary's MSS/ISS record.

Appropriate family planning counseling and referrals must be made and documented.

The initial assessment and up to nine professional visits per beneficiary, per pregnancy, are billable under MSS. The initial assessment and up to nine professional visits are billable under ISS. An additional nine ISS visits may be provided when requested in writing by the medical care provider. In these cases, reason for and purpose of additional visits must be well documented. The maximum number of reimbursable visits does not increase if two or more infants in the same family are concurrently at risk.

DRUG/ALCOHOL-EXPOSED INFANTS

A drug/alcohol-exposed infant is an infant born with the presence of an illegal drug(s) and/or alcohol in his/her circulatory system or living in an environment where substance abuse or alcohol is a danger. Due to the complex condition of these cases, they may require additional visits. A separate procedure code is assigned for additional visits. The beneficiary's record must contain documentation of the infant's drug/alcohol-exposed condition.

The maximum number of reimbursable visits is 36 in a year. Providers must use the professional visit code for the first 18 visits; for additional visits (subsequent 18), bill the drug/alcohol-exposed procedure code.

MISSED VISITS

Missed visits are not a reimbursable benefit under the Program. If a beneficiary is not home when agency staff goes to the beneficiary's home to provide a scheduled service, or if the beneficiary fails to appear for a scheduled office/clinic appointment, the Program will not reimburse the agency for the missed visit. A beneficiary may not be billed for a missed visit.

PLACE OF SERVICE

Maternal Support Services:

MSS professional visits may be provided either in a clinic/office setting, or in the beneficiary's home or place of residence (including homeless shelter), as determined appropriate by the MSS provider. Reasonable efforts should be made to visit the beneficiary at her home. The Program recommends that a minimum of two visits be made to the beneficiary's home. One such visit should be made at the time of assessment to get a better understanding of the beneficiary's background; another, after the birth of the infant, to observe bonding as well as proficiency in infant care and nutrition.

Infant Support Services:

ISS is a home-based program. The ISS assessment and **all** professional interventions **must** be done in the beneficiary's home. As an exception, due to client circumstances, it may not be feasible to provide services in the home. In this instance, services may be provided any place other than an inpatient hospital setting. However, on an average, **an agency** must provide 90% of all ISS professional visits in the home. Home visits will be reimbursed at a different rate than the visits occurring outside of the home.

TRANSPORTATION

The purpose of transportation is to assure beneficiaries keep their health care appointments.

The need for transportation must be assessed and transportation provided only if no other means are available to get to health care services.

The Program will cover beneficiary transportation for medical/health care, substance abuse treatment, WIC visits, or for any MSS services, including childbirth/parenting education classes. A mother's trip to visit her hospitalized infant is also covered. Transportation is available for an initial medical visit that will likely result in an enrollment in MSS or ISS. Under MSS, transportation is available for the pregnant woman. Under ISS, transportation is available for the infant and the primary caregiver.

Medicaid covers transportation services for all beneficiaries for obtaining medical care through the local Family Independence Agency. MSS/ISS providers should attempt to coordinate transportation services with the local Family Independence Agency office, which may have transportation resources available. Beneficiaries enrolled in the MSS/ISS Program can obtain transportation from the MSS/ISS provider.

For the Fee for Service Medicaid beneficiary, the MSS/ISS provider is required to offer and arrange for transportation needed. In recognition of this administrative requirement, the Program reimburses the provider an administrative fee equal to six percent of the cost of the transportation. When billing for transportation, the six percent fee should be calculated and included in the amount charged. The agency may contract for provision of transportation. Transportation service should be billed for each date of service it was provided.

For Medicaid Health Plan and CSHCS Special Health Plan enrollees, the subcontract with the health plans should indicate where the responsibility rests for making transportation available for beneficiaries enrolled in MSS/ISS.

The MSS/ISS provider must determine the most appropriate and cost-effective method of transportation. The Medicaid Program will reimburse transportation cost for:

- Bus,
- *Taxi, and
- Mileage (Volunteer/relative/beneficiary/other).

Reimbursement for all transportation services will be made for the lesser of **actual cost** or the maximum/upper limit set by the Program.

*If other methods of transportation are not available or appropriate, the MSS and/or ISS provider may make arrangements with local cab companies to provide taxi service for MSS or ISS beneficiaries. Since this is a more expensive service, the Program will reimburse a maximum of 20 trips each under MSS or ISS.

Transportation Documentation:

To account for the use of MSS or ISS transportation funds, the provider must maintain transportation documentation for each beneficiary provided such services. For each trip billed, a record must be made which specifies the name and address of the beneficiary, date of service, the trip's destination (address, city) and purpose, number of tokens or miles required for the trip, and amount which the beneficiary or transportation vendor was reimbursed. The provider must ensure the beneficiary kept the appointments for which transportation funds were provided.

The MSS and/or ISS provider may give transportation tokens or funds to the beneficiary/caretaker. In situations where funds are provided, it is recommended that the beneficiary sign a receipt, and that the receipt be retained in the case record.

EDUCATION CLASSES

MSS Childbirth Education Class:

For the purpose of this program, childbirth education is a series of group classes intended to help the woman understand (1) the changes her body is experiencing during pregnancy, (2) what to expect at the time of delivery, including information regarding pre-term labor and what to expect during the postpartum period, (3) how to care for the infant (classes may include information on developing positive parenting skills), and (4) to provide interaction with other pregnant women and to build a support network. First time mothers must be encouraged to complete the course.

The medical care provider or the MSS provider may make a referral for childbirth education classes. An assessment is not required if this is the only MSS service needed. Given appropriate referral, MSS providers may provide this service directly or have a subcontract with a local hospital's outpatient clinic to provide this service. An outpatient hospital clinic that provides this service may directly bill Medicaid for the Fee For Service beneficiaries. The subcontract agreement must indicate which provider has the responsibility to bill and receive payment. It is intended that these services be given to a group of individuals in a classroom situation when separately billed.

As an exception, childbirth education class may be provided in the beneficiary's home as a separately billable service. This is acceptable only given unusual circumstances, e.g., beneficiary entered prenatal care late or is homebound due to a medical condition. Case records should appropriately reflect the need for one-on-one childbirth education class and where services were provided.

SUGGESTED CONTENT FOR CHILDBIRTH EDUCATION CLASS

The MSS childbirth education class includes, but is not limited to, the following topics:

- Pregnancy
  - health care during pregnancy,
  - physical and emotional changes during pregnancy, and
  - nutrition.
- Labor and Delivery
  - signs and symptoms of labor, including information regarding pre-term labor,
  - breathing and relaxation exercises,

- analgesia and anesthesia,
- avoidance of complications,
- coping skills,
- types of deliveries,
- episiotomy,
- support techniques, and
- hospital tour.

➢ Infant Care

- preparation for breast feeding,
- infant feeding,
- immunizations,
- infant car seat use, and
- parenting.

➢ Postpartum

- postpartum physical and emotional changes including depression,
- feelings of partner,
- potential stress within the family,
- sexual needs,
- exercise, and
- the importance of family planning.

ISS Parenting Education Class:

Under the ISS Program, parenting education may be billed once per infant. Parenting education classes are intended to (1) develop positive parenting skills and attitudes, and (2) to provide interaction with the other parents and possibly build a support network.

The infant's medical care provider or the ISS provider may make a referral for ISS parenting education classes. An assessment is not required if this is the only ISS service needed. Given an appropriate referral, the services may be provided by the ISS provider or by way of a subcontract with an outpatient hospital or community based organization. It is intended that these services be given to a group of individuals in a classroom situation when separately billed.

SUGGESTED CONTENT FOR PARENTING EDUCATION CLASS:

The ISS parenting education class includes, but is not limited to, the following topics:

➢ Feeding recommendations throughout the first year of life

- nutritional requirements,

- developmental issues related to feeding children,
- bottle/breast feeding advantages, and
- formula preparation.

➢ Normal and abnormal patterns of elimination

- normal range of elimination patterns and changes throughout childhood, and
- toilet training issues and developmental readiness.

➢ Common signs and symptoms of infant illness

- appropriate care for common illness,
- danger signs and when to call the health care provider, and
- emergency numbers (i.e., poison control, emergency room, etc.).

➢ Common childhood injuries and how to care for them

- signs and symptoms to seek medical care,
- basic first aid, and
- accident prevention and safety.

➢ Normal range of sleep, rest, activity and crying patterns

- how to assist an infant in settling to sleep,
- normal patterns of sleep and activity and developmental changes,
- information on SIDS and appropriate sleeping position,
- signs and symptoms of over stimulation and under stimulation,
- how to quiet a crying baby, and
- how to play with a baby to encourage optimum developmental skills.

➢ Hygiene

- hygiene needs of infants, and
- appropriate care of routine problems (e.g., diaper rash, seborrhea, circumcision, etc.).

➢ Normal developmental milestones of infants through the first year

- discussion of developmental issues relating to providing care, feeding, and stimulation, and
- discussion of realistic expectations of infants in relationship to their developmental level.

- Emotional Needs
  - parent-infant interactions,
  - normal changes that occur throughout the first year of life and its impact on the infant-parent interaction, and
  - discussion and modeling of parenting behaviors which have a positive impact on the emotional well-being of the infant.
- Protection from toxic hazardous waste
  - paint,
  - lead, and
  - water.
- Immunizations and health maintenance
  - well baby visits,
  - American Academy of Pediatrics recommended schedule, and
  - care of the infant after immunizations.
- Day-to-day living with children
  - appropriate methods for managing activities and stress when living with infants and children,
  - second-hand smoking, and
  - appropriate ways of discipline.

Reimbursement:

Reimbursement for MSS childbirth education and ISS parenting education are for the complete class, regardless of the number of sessions needed to complete the class. At a minimum, the course outlined in the manual must be covered. Additional items may be added at the discretion of the provider. The pregnant woman (MSS) or mother (ISS) must attend at least one-half of the class or cover at least one-half of the curriculum for the service to be billed. Dates of attendance must be documented in the beneficiary's record. The class may be provided through a subcontract or a letter of agreement with the local hospital or community agency. The subcontract or letter of agreement must indicate the terms of reimbursement.

For MSS, childbirth education may be billed one time per beneficiary per pregnancy.

For ISS, parenting education may be billed one time per infant.

If the services are available at no charge to the public, neither the Medicaid Fee For Service program, the beneficiary's Medicaid Health Plan, CSHCS Fee For Service, or the Special Health Plan can be billed for the service.

TRANSFER OF CARE/RECORDS

During the course of care, the beneficiary may move to another area, thereby requiring services from a different provider. When an MSS and/or ISS provider is prospectively aware of such a move, the provider should advise the beneficiary of the availability of MSS and/or ISS providers at the new location. The referring provider must consult with the new provider about the case and transfer necessary information or records in compliance with privacy and security requirements of Health Insurance Portability and Accountability Act (HIPAA) regulations. A copy of the completed assessment and case summary must be shared with the new provider. Close coordination between providers should avoid duplication of services. A release of information from the beneficiary is necessary.

IMMUNIZATIONS

Agency staff is asked to be sensitive to the immunization status of children. Staff should check with the mother and/or physician involved with the family to determine whether the children are up-to-date with immunizations. Mothers should be encouraged to obtain immunizations and be helped in obtaining service, such as by offering assistance with transportation where needed.

Before closing an MSS and ISS case, immunization status must be assessed, appropriate action taken, and a recording, including dates of immunization when available, indicated in the case record.

SPECIAL ISS ARRANGEMENT WITH CHILDREN'S PROTECTIVE SERVICES WORKER

Because of the serious nature of MSS/ISS cases, some beneficiaries will need the assistance of the Michigan Family Independence Agency's Children's Protective Services (CPS) program. It is necessary that each MSS/ISS provider work cooperatively and on an ongoing basis with its local CPS office. Contact persons will need to be identified. Referral protocol and a working relationship will need to be developed and maintained. ISS is a valuable resource for the CPS program. It is most important that the ISS provider seek CPS assistance with potential CPS cases in a timely manner. It is expected that ISS and CPS will work concurrently on at least some referred cases. CPS is not to be viewed as recourse of last resort – the agency to call when all else fails.

The Michigan Child Protection Law (Act No. 238, Public Acts of 1975) requires health care professionals and others to report cases of suspected child abuse/neglect to CPS. When and how the ISS provider must refer can best be determined by discussions with the local CPS agency. ISS activity does not replace the necessity for required CPS referrals.

COMMUNICATION WITH MEDICAL CARE PROVIDER

When an MSS/ISS case is opened without the medical care provider's involvement, the medical care provider must be notified within 7 to 14 days that the beneficiary is enrolled in the MSS/ISS program. The MSS/ISS provider must keep the medical care provider informed of the services provided to the beneficiary through notification of significant changes or as directed by the medical care provider. At case closing of MSS/ISS, a discharge summary must be completed and forwarded to the medical care provider and must include the services provided, outcomes, current status, and ongoing needs of the beneficiary.

FORMS

Based on the recommendations of the recent Maternal Support Services program evaluation, the Department has developed standardized forms to be used by all Maternal and Infant Support Services (MSS/ISS) providers in rendering services. The Department has developed these forms and included them in the Forms Appendix. Providers may copy these forms for agency use. At a minimum, the data elements included in these forms must be maintained; additional data elements may be incorporated to fit agency/community needs.

The following forms have been developed and **must** be used when providing MSS and ISS services:

- MSS/ISS Authorization and Consent to Release Protected Health Information (DCH-1190)
- MSS Risk Screening (DCH-1191)
- MSS Initial Assessment (DCH-1192)
- MSS Plan of Care (DCH-1193)
- ISS Risk Screening (DCH-1194)
- ISS Initial Assessment (DCH-1195)
- ISS Plan of Care (DCH-1196)
- MSS/ISS Professional Visit Progress Note (DCH-1197)
- MSS Discharge Summary (DCH-1198)
- ISS Discharge Summary (DCH-1199)

The forms are also located on the MDCH website at www.michigan.gov/mdch. When at this site, click on 1.) Providers (left side of the screen), 2.) Information for Medicaid Providers (left side of screen), and 3.) Medicaid Provider Forms and Other Resources (center of the screen).

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MSS CASE RATE

For the Fee For Service beneficiaries, an alternate reimbursement option is available. In counties where there is no Maternal Support Services (MSS) provider, MDCH may consider the MSS case rate reimbursement plan for the Fee For Service beneficiaries. Under this plan, the reimbursement is based on the number of Medicaid deliveries in the service area. The provider will have the responsibility of screening all Medicaid Fee For Service pregnant women for eligibility for MSS services. Pregnant women that qualify would be offered MSS services.

MSS providers in the case rate program should develop and implement a program to meet performance goals as established by MDCH. The performance goals to be obtained include the following:

- Screening 90% of the Medicaid Fee For Service pregnant women,
- Reducing by 10% the incidence of smoking among Medicaid Fee For Service pregnant women, and
- Assuring that Medicaid Fee For Service pregnant women receive an appropriate number of prenatal care visits.

To help monitor the case rate program, providers will be required to provide, at a minimum, the following information for the beneficiaries served in each calendar quarter. This data will also help each agency review how their program is working and if it is achieving the goals and objectives of the MSS program.

- MSS Reporting Requirements:
  - Number of risk assessments (screening) conducted,
  - Number of Medicaid Fee For Service women identified through outreach activities,
  - Number referred by physician,
  - Number referred by MSS provider,
  - Number of women enrolled in MSS,
  - Number and types of individual MSS visits provided.

Providers opting for case rate reimbursement program will need to sign a separate contract with the MDCH. This contract will outline the policy and procedures for this program.

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CERTIFICATION CRITERIA FOR MATERNAL AND INFANT SUPPORT SERVICES PROVIDERS

The Michigan Department of Community Health (MDCH), Health Programs Administration, Bureau of Children and Family Programs, Division of Family and Community Health is responsible for Maternal Support Services (MSS) and Infant Support Services (ISS) provider certification.

This is the criteria by which MDCH will determine whether, or under what conditions, an agency is qualified to provide MSS and/or ISS. Provider participation criteria are as follows:

- The provider must qualify to be an enrolled provider in the Medicaid Program.
- In cases where services are to be provided through a subcontractor, the subcontract or letter of agreement must be on file for review by the certifying agency. The letter of agreement must indicate the time period of the agreement, the names of the individuals providing services and where the billing responsibility lies.
- Physical facilities for seeing beneficiaries must be comfortable, safe, clean, and meet legal requirements.
- The provider must have experience in the delivery of services to the target population and a demonstrated understanding of the concept and delivery of Maternal and/or Infant Support Services. The provider must demonstrate linkages to relevant services and health care organizations in the area to be served.
- The organization shall demonstrate a capacity to conduct outreach activities to the target population and to medical care providers in the geographic area to be served.
- Staff for the program must comprise an interdisciplinary team and must include the following disciplines and qualifications:
    - ❖ Nursing - (1) Possession of a MSN or BSN and at least one year of providing community health, pediatric and/or maternal/infant nursing services; or (2) Possession of a Diploma or ADN and at least two years of providing community health, pediatric and/or maternal/infant nursing services. All nurses must be in possession of a current Michigan license to practice nursing in Michigan under Part 172 of Michigan Public Act 368 of 1968, as amended.
    - ❖ Social work - (1) Registration as a Certified Social Worker (CSW) or ACSW and one year of providing services to families; or (2) Possession of an MSW and one year of providing services to families; or (3) Possession of a BSW or RSW and one year of providing services to families.
    - ❖ Nutrition - (1) MPH with emphasis in nutrition or Master's degree in human nutrition; or (2) Bachelor of Science and registration as a dietician (RD); or (3) Bachelor of Science and RD-eligible with examination pending in 6 months or less. Each of the above-degreed nutritionists must have at least one year of providing community health, pediatric, and/or maternal/infant nutrition services.

- Staff for the ISS program may include the following as an additional member of the multidisciplinary team:

  - ❖ Infant Mental Health Specialist – A person with a bachelor's or a master's degree in psychology, child development, social work, or nursing and possessing either (1) certification in infant mental health from Wayne State University, or (2) specialized instruction in parent-infant assessment and intervention. Not less than one year of experience in an infant health program is also required.

  Agencies unable to meet staffing requirements may submit written requests for waivers to:

  Director
  Division of Family and Community Health
  Bureau of Children and Family Programs
  Michigan Department of Community Health
  P.O. Box 30195
  3423 N. Martin L. King, Jr., Blvd.
  Lansing, Michigan 48909

  OR fax requests to 517-335-8294

  The MDCH will examine the validity of each waiver request and approve or disapprove accordingly.

- The provider must demonstrate its ability to validate the need for MSS/ISS and to deliver MSS/ISS appropriate to the individual beneficiary's level of need. The provider must specifically address the ability to:

  - ❖ respond to referrals promptly to meet the beneficiary's need, within a maximum of 7 days for ISS and 14 days for MSS;
  - ❖ report disposition of the referral (i.e., initiation of services, inability to locate, or denial of services) to the referring source within one week of receipt;
  - ❖ notify the medical care provider of beneficiary's enrollment within a maximum of 14 days;
  - ❖ complete an assessment, based on a home visit as required for ISS and, if possible, for MSS, and develop a plan of care;
  - ❖ schedule services to accommodate the beneficiary's situation;
  - ❖ provide for weekend and after-hours emergencies;
  - ❖ provide directly or arrange for bilingual services, services for the blind or deaf, as indicated;
  - ❖ coordinate agency and community services for the beneficiary;
  - ❖ arrange for needed beneficiary transportation;
  - ❖ be aware of local public health programs such as Women, Infants, and Children Supplemental Food Program (WIC); Early and Periodic, Screening, Diagnosis and Treatment (EPSDT); Children's Special Health Care Services (CSHCS); and other agencies that may have appropriate services to offer the beneficiaries and agree to work cooperatively with these agencies;

- ❖ collaborate for ISS, with the hospital staff to assure the transitioning of the infant from hospital to home. Assessments should be conducted within 48 hours of discharge for referrals received prior to the beneficiary's discharge from inpatient setting;
- ❖ have written protocols for adhering to the reporting requirements as mandated by the Child Protection Law (Act No. 238, Public Acts of 1975);
- ❖ report on a monthly basis all new enrollees to the health plan;
- ❖ have a referral system to other community agencies;
- ❖ provide ongoing communication with the beneficiary's medical care provider;
- ❖ provide directly the services of at least one of the three disciplines. The other discipline(s) may be provided through a subcontractor;
- ❖ be able to provide services in a clinic, an office, or a home setting, as appropriate;
- ❖ demonstrate a system for handling beneficiary grievances;
- ❖ maintain an adequate and confidential beneficiary records system, including services provided under a subcontract;
- ❖ have written internal protocols to include all aspects of the MSS/ISS;
- ❖ establish protocols with the local Family Independence Agency's Children's Protective Services (CPS) unit to assure participation in or access to the local CPS multidisciplinary team meetings, including referral process and follow-up contacts as appropriate for ISS;
- ❖ be a member of the local Part C/Early On Interagency Coordinating Council, or is otherwise actively linked to it (for ISS).

Based upon satisfactory application, MDCH will provide an interim MSS and/or ISS certification. After an agency is certified and is providing services, MDCH will conduct a provider site visit. The site visit will occur within six months of the interim certification. The purpose of the site visit is two-fold: 1) to observe how the program is being implemented, and 2) to help resolve any problems that may be experienced in implementation of the Program. Based upon the site visit, MDCH will grant the agency either a six-month certification, a three-year certification, or an existing certification may be discontinued. MDCH will make subsequent formal certification visits every three years, with informal site visits in between.

At any time after receiving certification, if the provider becomes deficient in any of the qualifying criteria, including staffing issues, the provider must notify the certifying agency **immediately**. The certifying agency will then determine whether the agency may continue providing services given the deficiency(ies). The certifying agency's decision will be based upon the number of deficiencies, the specific deficiency(ies) involved, the availability of other providers in the area, impact on caseload, etc.

If at any time the MSS/ISS provider fails to meet the program policies or certification requirements, reimbursement received from Medicaid can be jeopardized. Like all Medicaid providers, the MSS/ISS provider is subject to being audited by Medicaid and if at that time any discrepancy(ies) are found, appropriate follow-up actions may be taken, such as recoupment of payments, holding reimbursement on claims, or terminating enrollment from the Program. Also, like all Medicaid providers, if a negative action is proposed, the MSS/ISS provider would be given an opportunity for appeal.

Agencies wishing to apply to become a MSS/ISS services provider may write to:

Program Policy Division
Policy and Legal Affairs Administration
Michigan Department of Community Health
400 South Pine Street
P.O. Box 30479
Lansing, Michigan 48909-7979

PROCEDURE CODE APPENDIX

When billing for Maternal Support Services (MSS) and Infant Support Services (ISS), providers must use the unique Medicaid Provider Type 77 identification number assigned to that agency at the time of enrollment in the MSS/ISS program. Providers must use the HCFA 1500 (paper) claim form or ASC X 12N 837, version 4010 (electronic) claim, with the appropriate procedure codes indicated below. The information provided in this appendix must be used in conjunction with the information contained in Billing and Reimbursement, Chapter IV of this Manual. When billing for MSS, use the Medicaid ID Number of the pregnant woman. For ISS, use the infant's ID Number.

Maternal Support Services

Procedure Code		Description
Z0001	MSS	Psychosocial/Nutritional Assessment in Office/Clinic
Z0002	MSS	Professional Visit in Clinic/Office
Z0003	MSS	Professional Visit in Home
Z0004	MSS	Psychosocial/Nutritional Assessment in Home
Z0005	MSS	Childbirth Education Class
Z0006	MSS	*Screening (Health Plan Clients only)
Z0010	MSS	Transportation – Bus
Z0011	MSS	Transportation – Taxi
Z0012	MSS	Transportation – Volunteer Mileage
Z0013	MSS	Transportation - Other

*The Medicaid Health Plans may report MSS screens performed on their enrollees using code Z0006. This is for health plans only and there is no reimbursement for this code.

Infant Support Services

Procedure Code		Description
Z0020	ISS	Psychosocial/Nutritional Assessment in Home
Z0021	ISS	Professional Visit in Home
Z0022	ISS	Professional Visit other than Home
Z0024	ISS	Additional Professional Visit for Drug/Alcohol-Exposed Infants
Z0025	ISS	Parenting Education
Z0030	ISS	Transportation - Bus/Van
Z0031	ISS	Transportation – Taxi
Z0032	ISS	Transportation - Volunteer Mileage
Z0033	ISS	Transportation – Other

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FORMS APPENDIX

Attached for your use/adaptation are the following forms:

- MSS/ISS Authorization and Consent to Release Protected Health Information (DCH-1190)
- MSS Risk Screening (DCH-1191)
- MSS Initial Assessment (DCH-1192)
- MSS Plan of Care (DCH-1193)
- ISS Risk Screening (DCH-1194)
- ISS Initial Assessment (DCH-1195)
- ISS Plan of Care (DCH-1196)
- MSS/ISS Professional Visit Progress Note (DCH-1197)
- MSS Discharge Summary (DCH-1198)
- ISS Discharge Summary (DCH-1199)

The forms are also located on the MDCH website at www.michigan.gov/mdch. When at this site, click on 1.) Providers (left side of the screen), 2.) Information for Medicaid Providers (left side of screen), and 3.) Medicaid Provider Forms and Other Resources (center of the screen).

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MATERNAL AND INFANT SUPPORT SERVICES PROGRAM

Authorization and Consent to Release Protected Health Information

The Maternal Support Services (MSS) and Infant Support Services (ISS) Programs are designed to provide you with information and referrals to agencies that may help you stay healthy and care for you 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 following 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 in the Michigan Department of Community Health (MDCH) and the local Family Independence Agency (FIA). To assure that program services are coordinated with your primary health care, we may also need to provide information regarding services you receive, or need to receive, with your physician and other community agencies.

If you qualify for program services, your participation will be completely voluntary. You may refuse to answer any questions that you do not wish to answer. You are free to end the interview at any time. If you decide not to answer some of the questions or if you decide to end the interview, it will not affect your Medicaid eligibility or your ability to receive MSS or ISS for you or your infant.

I have read the above or have had it read/explained to me. I understand that I may qualify to receive MSS or ISS.

☐ I **do not** wish to participate in the MSS or ISS assessment and do not want to receive MSS or ISS for myself or my infant.

☐ I **do** wish to participate in the MSS or ISS assessment and want to receive MSS or ISS for myself or my infant. I also authorize the release of information to other community agencies to assist in my care.

Print Beneficiary's Name

_____

_____

Beneficiary's Signature Date

_____

Name of Interviewer Date

MATERNAL SUPPORT SERVICES
RISK SCREENING TOOL

Beneficiary Referred For MSS
❑ Yes ❑ No

Beneficiary Name: _____ **D.O.B.:** _____
Last First Middle
E.D.C.: _____
Medicaid ID #: _____ **County:** _____
Address: _____ **Telephone:** _____
Beneficiary's Parent/ Guardian/Spouse: _____ **Alternate Telephone:** _____
Additional Contact Person: _____ **Telephone Number:** _____

Health Care (Obstetrical) Provider
Name: _____ **Telephone Number:** _____
Address: _____
Medicaid Health Plan Name: _____

---

1. Need for childbirth education
Do you know what to expect at different stages of your pregnancy? ☐ Yes ☐ No
Would you like to learn more about delivery? ☐ Yes ☐ No
Do you have experience in caring for a baby? ☐ Yes ☐ No
Would you like to learn more about how to take care of your baby? ☐ Yes ☐ No

2. Need for transportation to keep medical appointments
How do you get around? ☐ By car ☐ Public transport
How do you plan to get to medical appointments?
_____

3. Need for assistance to care for your infant
Are you good at following directions/instructions? ☐ Yes ☐ No
Barriers: ☐ language ☐ literacy* Education level _____
Physical limitations _____

Describe where you live:
☐ Rent ☐ Own your home ☐ With relatives
☐ Shelter* ☐ Motel* ☐ Car*

4. Nutrition/Health problems
Describe your eating habits
No. of meals eaten per day _____ ☐ Skip meals*
☐ Cook at home ☐ Fast food
Which beverages do you drink often?
☐ Pop ☐ Juice ☐ Water ☐ Milk
Do have any food cravings, e.g. PICA? ☐ Yes* ☐ No
Is your blood low in iron (anemia)? ☐ Yes* ☐ No
Do you have high blood pressure? ☐ Yes* ☐ No
Do you have diabetes now or during other pregnancies? ☐ Yes* ☐ No
Have you had problems with weight gain/loss during your pregnancy? ☐ Yes* ☐ No
Do you have any other health problems that concern you?
Explain _____

5. Family support
Are you under 18 years old? ☐ Yes* ☐ No
Who do you currently live with? _____
Who supported you during pregnancy? _____
Who can you count on for support from?
The baby's father? ☐ Yes ☐ No*
A parent? ☐ Yes ☐ No*
A friend? ☐ Yes ☐ No*
Anyone else? _____

6. Feelings about current pregnancy
Have you been pregnant before? _____
What are your feelings about this pregnancy?
☐ Happy ☐ Unhappy* ☐ Don't Know
Did your last pregnancy result in fetal (womb) or neonatal (within 30 days of birth) death?
☐ N/A ☐ Yes* ☐ No
Have you experienced death of a prior child before age one?
☐ N/A ☐ Yes* ☐ No

7. Mother with cognitive, emotional or mental needs
How are you coping with taking care of your baby?
☐ Good ☐ Bad* ☐ O.K.
Do you feel stressed? ☐ Yes* ☐ No
Do you have a history of postpartum depression? ☐ Yes* ☐ No
Do you have any concerns about your mental or emotional health? ☐ Yes* ☐ No

8. Social situation
Do you worry about somebody mistreating you? ☐ Yes* ☐ No
Do you worry about anyone mistreating your child/children? ☐ Yes* ☐ No
Are you planning on moving during your pregnancy?
☐ Yes ☐ No ☐ Don't Know

9. Use of alcohol, drugs or tobacco products
Do you smoke? ☐ Yes* ☐ No
Do you drink alcohol (beer, wine, liquor) now that you are pregnant? ☐ Yes* ☐ No
Do you use street drugs? ☐ Yes* ☐ No
Does someone in your household use street drugs? ☐ Yes* ☐ No

A Check/Yes response to any asterisk (*) question indicates automatic referral for MSS.

Beneficiary's Name: _____

MATERNAL SUPPORT SERVICES
RISK SCREENING TOOL

10. Other (explain): _____

_____

_____

_____

_____

_____

_____

Completed by: _____ **Date:** _____

INSTRUCTIONS:

1. If the responses to Items 2-10 indicate no other high-risk situation, and responses to questions in Item 1 indicate no experience or knowledge of dealing with pregnancy/baby, the beneficiary needs only Childbirth Education. Enrollment in MSS is not required.
2. Based on the responses to questions for Item 2, assess the need for transportation and, as appropriate, make arrangements to transport beneficiary for appointments.
3. A check/yes response to an asterisk (*) question indicates an automatic referral for MSS. Non-asterisk items should be referred based on provider judgment.

BENEFICIARY:

I understand I may qualify to receive MSS, but I do not want these services.

Signature: _____ **Date:** _____

MEDICAL or MSS CARE PROVIDER

Signature: _____ Date: _____

Print Name: _____

A Check/Yes response to any asterisk (*) question indicates automatic referral for MSS.

Medicaid ID #: _____
Date of Assessment:_____
Type: Open Card or Fee For Service_____ Managed Care (MHP):_____
Non-Medicaid:
☐ Application in process. Explain_____
☐ Not yet applied. Explain _____

Location: ☐ Home Visit ☐ Other Visit ☐ Office Visit

Has the consent form been signed? ☐YES ☐NO

Maternal Support Services
INITIAL ASSESSMENT

GENERAL INFORMATION

Beneficiary's First Name _____ Last Name _____ Date of Birth ____/_____/____

Phone Number _____(hm) _____(wk) Best time to reach Beneficiary _____

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

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 name of all members)*	Relationship to Beneficiary	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.

Beneficiary's Name: _____

HEALTH INFORMATION

MATERNAL HEALTH

1. Do you have a prenatal care provider that accepts Medicaid? ☐ YES ☐ NO
   If no, what kind of problem have you had in selecting a provider? _____
   _____
2. Have you had a prenatal visit with a prenatal care provider? ☐ YES ☐ NO
   a. Name of prenatal care provider _____
   b. Address/Location_____
   c. How many weeks or months pregnant were you on your first visit for prenatal care?_____
3. Did you get prenatal care as early as you wanted? ☐ YES ☐ NO
   If no, check all that apply:
   - ☐ no one to take care of your children
   - ☐ had no way to get to the clinic or office
   - ☐ could not get a doctor or nurse to take you as a patient
   - ☐ could not get an appointment earlier
   - ☐ other _____
   - ☐ did not think you were pregnant
   - ☐ did not have enough money or insurance to pay for visits
   - ☐ did not have your Medicaid card
   - ☐ did not know where to go
4. Are you satisfied with the prenatal care you are receiving now? ☐ 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 prenatal care provider
   - ☐ amount of time the doctor or nurse spent with you during your visits
   - ☐ advice you received on how to take care of yourself
   - ☐ hours the office or clinic was open
   - ☐ understanding and respect the staff showed towards you as a person
5. What is your due date?_____If unknown, when did your last menstrual period start?_____
6. Do you have any health problems?_____
   _____
7. Previous Pregnancies:
   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_____
      _____
   e. Did you have a six-week check-up (postpartum) after your last pregnancy? ☐ YES ☐ NO
8. Family Planning:
   a. Were you using birth control when you became pregnant with this child? ☐ YES ☐ NO
      If no, do you consider this a wanted pregnancy? ☐ YES ☐ NO
      If no, do you need help with making decisions about completing this pregnancy? ☐ NO ☐ YES
   b. What do you want to use for birth control after your baby is born?_____
9. 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:
   a. During this pregnancy? ☐ YES ☐ NO
   b. After this pregnancy? ☐ YES ☐ NO
4. Do others smoke around you inside your home? ☐ YES ☐ NO
5. Do fellow workers smoke around you on the job? ☐ YES ☐ NO

Beneficiary's Name: _____

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
3. Are the immunization records on all preschool children in the household available? ☐ YES ☐ NO

NUTRITION

1. What was your weight just before this pregnancy? _____ Current weight? _____ Height? _____
2. How much weight would you like to gain with this pregnancy? _____
3. Have you had any of the following problems?
   ☐ change in appetite ☐ constipation ☐ diarrhea ☐ food allergies ☐ heart burn ☐ nausea ☐ vomiting
4. What changes have you made in eating since you found out you are pregnant?_____
   a. Are you on a special diet? ☐ NO ☐ YES
      If yes, please describe _____
   b. Are you able to drink milk and eat milk products? ☐ YES ☐ NO
   c. Do you feel the need to eat any non-food, such as ice, clay, starch, etc.? ☐ YES ☐ NO
      If yes, what_____
   d. Have you ever had an eating disorder, such as bulimia or anorexia nervosa? ☐ NO ☐ YES
      If yes, please explain _____
   e. How often do you eat fast foods in a week? _____
   f. How many pops/Kool-aid do you drink in a day? _____
   g. How many cups of coffee/tea do you drink in a day? _____
   h. How many glasses of water do you drink in a day? _____
   i. Describe a typical day's meals: _____
      _____
5. Do you have enough food for three meals a day? ☐ YES ☐ NO
   a. Do other family members have enough food? ☐ 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?_____
6. Are you taking a prenatal vitamin daily? ☐ YES ☐ NO
   a. Are you taking herbal supplements? ☐ NO ☐ YES
7. Breast-Feeding
   a. Are you planning to breast-feed this baby? ☐ YES ☐ NO
   b. What concerns do you have about breast-feeding? _____
      _____

SEXUALLY TRANSMITTED INFECTIONS

1. Have you or your partners been treated with blood products prior to 1985? ☐ NO ☐ YES ☐ Don't know
2. Have you or someone you've had sex with used needles to take drugs? ☐ NO ☐ YES ☐ Don't know
3. Have you had more than one sex partner? ☐ NO ☐ YES
4. Have you had sex without using a condom in the last 12 months? ☐ NO ☐ YES ☐ Don't know
5. Have you had or been treated for any of the following STIs?
   ☐ Chlamydia ☐ Genital Warts ☐ Gonorrhea ☐ Hepatitis B ☐ Herpes ☐ Syphilis ☐ Trichomoniasis
6. Has your current partner or father of the baby ever had a STI? ☐ NO ☐ YES ☐ Don't know
7. Have you had a test for HIV during this pregnancy? ☐ YES ☐ NO
8. Would you like more information on HIV? ☐ YES ☐ NO

EMOTIONAL/ MENTAL HEALTH INFORMATION

MENTAL STRESS

1. Are you a first-time parent? ☐ NO ☐ YES
   a. What are your concerns about being a parent? _____
2. How does your partner feel about this baby? _____
3. Is your partner the father of the baby? ☐ YES ☐ NO
   a. If no, what is your current relationship with the father of the baby? _____

Beneficiary's Name: _____

4. Who can you depend on when you need help or someone to talk to? _____

5. Have you felt isolated during this pregnancy? ☐ NO ☐ YES
   If yes, please describe _____

6. Are there issues now that are particularly stressful? ☐ NO ☐ YES
   If yes, please describe _____
   a. How do you normally cope with stress? _____
   b. Have you experienced any recent losses (i.e., death, stillbirth, miscarriage, job)? ☐ NO ☐ YES
      If yes, please describe _____

7. Depression
   a. Have you had any of these feelings since being pregnant?
      ☐ 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
8. Have you or a family member been involved with Children's Protective Services (CPS)? ☐ NO ☐ YES
9. Domestic Violence – Since you have been pregnant
   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. Within the last year, has anyone forced you to have sexual activities? ☐ NO ☐ YES
      If yes, who_____
   d. Are you fearful of your safety at this time? ☐ NO ☐ YES
10. Have you ever received counseling and sought other resources? ☐ NO ☐ YES

ALCOHOL/ DRUG USE

1. Alcohol
   a. During the three months before you became pregnant, how many alcoholic drinks did you have in an average week? (A drink is one glass of wine, one wine cooler, one can or bottle of beer, one shot of liquor, or one mixed drink.)
      ☐ did not drink then ☐ less than one drink per week ☐ 1- 3 drinks per week ☐ 4-6 drinks per week
      ☐ 7-13 drinks per week ☐ 14 or more drinks per week ☐ don't know
   b. During the three months before you became pregnant, how many times did you drink five or more alcoholic drinks in one setting?
      ___ times ☐ did not drink then ☐ don't know
   c. Since you became pregnant, how many alcoholic drinks have you had in an average week?
      ☐ do not drink now ☐ less than one drink per week ☐ 1- 3 drinks per week ☐ 4-6 drinks per week
      ☐ 7-13 drinks per week ☐ 14 or more drinks per week
   d. Since you became pregnant, how many times have you drunk five or more alcoholic drinks in one setting?
      ___ times ☐ don't drink now ☐ don't know
2. Drug
   a. Which of the following prescription medications do you take now? (Check all that apply.)
      ☐ allergy medication ☐ antibiotics ☐ antiseizure ☐ vitamins
      ☐ Demerol, morphine ☐ sleeping pills ☐ hormones ☐ diet pills or amphetamines
      ☐ pain killers ☐ steroids ☐ Methadone ☐ antidepressants or mood regulators
      ☐ other prescribed medications_____
   b. Some mothers tell us that the stress of their pregnancy is so high they use street drugs while they are pregnant. Which of these recreational or street drugs have you taken during this pregnancy?
      ☐ Crack ☐ Cocaine ☐ Heroin ☐ Marijuana or Hashish
      ☐ Methadone ☐ PCP, angel dust, LSD ☐ Speed/Uppers
      ☐ Other_____
   c. Have you ever been arrested due to drugs or alcohol use? ☐ NO ☐ YES
      If yes, please describe_____

Beneficiary's Name: _____

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 _____
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. Do you have a crib for your new baby? ☐ YES ☐ NO
19. Do you need help getting baby items? ☐ NO ☐ YES

CHILDBIRTH EDUCATION CLASSES (CBE)

1. Are you nervous about going through the labor and delivery process? ☐ NO ☐ YES
   If yes or no, explain: _____
2. Who will be taking you to the hospital when you are in labor? _____
3. Who will be your coach/with you during delivery? _____
4. Have you ever taken a CBE class? ☐ YES ☐ NO
5. Do you plan to take a CBE class? ☐ YES ☐ NO
6. 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 increased appointments due to the pregnancy? _____
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

Beneficiary's Name: _____

SUMMARY

BENEFICIARY SUMMARY

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

CLINICIAN ASSESSMENT SUMMARY

Strengths:

Weaknesses:

Referrals Made:

I have provided a copy of the following MSS program information:

☐ Beneficiary grievance policy/procedure

☐ Medical and non-medical emergency options

MSS assessment form completed by:

Signature Discipline Date

MATERNAL SUPPORT SERVICES PLAN OF CARE

Beneficiary Name	Date of Birth	E.D.C	Gravida	Para	Medical Care Provider

Care Coordinator	Discipline

PROBLEMS/ NEEDS	GOALS/ OBJECTIVES	INTERVENTIONS
Health		
Family Planning	Assist beneficiary/family to achieve their goal of spacing and composition of family through use of birth control method of her choice.	
Smoking ☐ Beneficiary Amount _____ ☐ Quit Smoking When _____ ☐ Environmental Smoke Who _____ ☐ Smoke-Free Environment	Beneficiary will have a smoke-free environment.	
Immunization Status for Mother (Based on Immunization Record/MCP) ☐ Up To Date ☐ Not Up To Date Status of Preschool Child(ren) (Based on MICR/Immunization Record/MCP) ☐ Up To Date ☐ Not Up To Date	Beneficiary will remain current with immunizations.	
Nutrition		

Beneficiary's Name: _____

MATERNAL SUPPORT SERVICES PLAN OF CARE

PROBLEMS/ NEEDS	GOALS/ OBJECTIVES	INTERVENTIONS
Emotional/ Mental Health		
Alcohol/ Drug Use		
Environmental		
Childbirth Education Class	Beneficiary will receive the benefits of a group setting.	
Transportation	Beneficiary will not miss any appointments due to a lack of transportation.	
Other		

We the undersigned have reviewed the initial assessment and have participated in the above described plan. We concur with the number of visits to implement the interventions.
Estimated Number of Visits By: _____RN _____SW _____RD

RN Signature	Date	SW Signature	Date	RD Signature	Date

Care Plan Update

We the undersigned have reviewed the care plan update and agreed to the changes in the above described plan. We concur with the number of visits to achieve the specific objectives.
Estimated Number of Visits By: _____RN _____SW _____RD

RN Signature	Date	SW Signature	Date	RD Signature	Date

INFANT SUPPORT SERVICES
RISK SCREENING TOOL

Infant Referred For ISS
❑ **Yes** ❑ **No**

Infant Name: _____ (Last / First / Middle) **D.O.B.:** _____

Medicaid ID #: _____ **County:** _____

Address: _____ **Telephone:** _____

Mother/Caregiver: _____ **Alternate Telephone:** _____

Additional Contact Person: _____ **Telephone Number:** _____

Medical Care Provider

Name: _____ **Telephone Number:** _____

Address: _____

Medicaid Health Plan Name: _____

---

1. Need for assistance to care for your infant
Are you good at following directions/instructions? ☐ Yes ☐ No
Barriers: ☐ language ☐ literacy* Education level _____
Physical limitations _____

Describe where you live:
☐ Rent ☐ Own your home ☐ With relatives
☐ Shelter* ☐ Motel* ☐ Car*

2. Failure to thrive
How often do you feed your baby in a day? _____
Do you: ☐ Breast feed ☐ Bottle feed
Supplement with _____
Is your baby losing weight? ☐ Yes* ☐ No
Does your baby have any other health problems that concern you?

Explain: _____
_____

3. Mother with cognitive, emotional or mental needs
How are you coping with taking care of your baby?
☐ Good ☐ Bad* ☐ O.K.
Do you feel stressed? ☐ Yes* ☐ No
Do you have a history of postpartum depression? ☐ Yes* ☐ No
Do you have any concerns about your mental or emotional health? ☐ Yes* ☐ No

4. Low Birth Weight
What was the birth weight of your baby? _____
☐ >2500 grams or ☐ <2500 grams
What week of the pregnancy was your baby born? _____

5. Family support
Are you under 18 years old? ☐ Yes* ☐ No
Who do you currently live with? _____
Who supported you during pregnancy? _____
Who can you count on for support from?
the baby's father? ☐ Yes ☐ No*
a parent? ☐ Yes ☐ No*
a friend? ☐ Yes ☐ No*
Anyone else? _____

6. Homeless/dangerous living situation
Do you worry about anyone mistreating your child/children? ☐ Yes* ☐ No
Do you/baby feel safe in your home? ☐ Yes ☐ No*
Are you planning on moving from current location?
☐ Yes ☐ No ☐ Don't Know

7. Family history of mother's abuse/neglect
Have you ever been abused? ☐ Yes* ☐ No
Have you ever been neglected? ☐ Yes* ☐ No

8. Abuse of alcohol, street drugs or tobacco products
Do you smoke? ☐ Yes* ☐ No
Do you drink alcohol (beer, wine, liquor) when you are pregnant? ☐ Yes* ☐ No
Do you use drugs not prescribed by your doctor? ☐ Yes* ☐ No
Does someone in your household use drugs? ☐ Yes* ☐ No

9. Any other condition that may place the infant at risk for death, illness, or significant impairment?

Explain

_____
_____
_____

Completed by: _____ **Date:** _____

Note: A yes or check to an asterisk (*) question indicates a referral of ISS. Provider judgment must be used in making appropriate referrals.

Infant's Name: _____

INFANT SUPPORT SERVICES
RISK SCREENING TOOL

INSTRUCTIONS:

1. If the responses to Items 2-10 indicate no other high-risk situation, and responses to questions in Item 1 indicate no experience or knowledge of dealing with pregnancy/baby, the beneficiary needs only Parenting Education. Enrollment in ISS is not required.
2. Based on the responses to questions for Item 2, assess the need for transportation and, as appropriate, make arrangements to transport beneficiary for appointments.
3. A check/yes response to an asterisk (*) question indicates an automatic referral for ISS. Non-asterisk items should be referred based on provider judgment.

CAREGIVER:

I understand I may qualify to receive ISS, but I do not want these services.

Signature: _____ **Date:** _____

MEDICAL or ISS CARE PROVIDER

Signature: _____ Date: _____

Print Name: _____

Note: A yes or check to an asterisk (*) question indicates a referral of ISS. Provider judgment must be used in making appropriate referrals.

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

Infant Support Services
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 *(Complete questions which have not been answered for Maternal Support Services Program)*

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 *(Complete questions which have not been answered for Maternal Support Services Program)*

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_____

Infant's Name: _____

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
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? _____

Infant's Name: _____

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

Infant's Name: _____

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 _____
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 ISS program is about? ☐ YES ☐ NO
2. What do you want the ISS team to work with you on? _____
   _____
3. Do you foresee any problems keeping appointments with the ISS team? ☐ NO ☐ YES
   What kind? _____
   _____

Infant's Name: _____

CLINICIAN ASSESSMENT SUMMARY

Strengths:

Weaknesses:

Referrals Made:

I have provided a copy of the following ISS program information:

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

ISS assessment form completed by:

Signature	Discipline	Date

INFANT SUPPORT SERVICES PLAN OF CARE

Infant Name:	Date of Birth	Birth Weight	Birth Ht/Length	Gestational Age	Medical Care Provider:
Caregiver Name:					
Care Coordinator:					Discipline

PROBLEMS/NEEDS	GOALS/OBJECTIVES	INTERVENTIONS
Health:		
Family Planning:	Assist family to achieve their goal of spacing and composition of family through use of birth control method of their choice.	
Smoking: ☐ Caregiver Amount ____ ☐ Quit Smoking When ____ ☐ Environmental Smoke Who ____ ☐ Smoke-Free Environment	Infant will have a smoke-free environment.	
Immunization Status of Caregiver (Based on Immunization Record/MCP) ☐ Up To Date ☐ Not Up To Date Status of Preschool Child(ren) (Based on MICR/Immunization Record/MCP) ☐ Up To Date ☐ Not Up To Date	Infant will remain current with immunizations.	
Nutrition:		

Infant Name: _____

INFANT SUPPORT SERVICES PLAN OF CARE

PROBLEMS/NEEDS	GOALS/OBJECTIVES	INTERVENTIONS
Emotional/Mental Health		
Environmental:		
Parenting Class:	Caregiver will receive the benefits of a group setting.	
Transportation:	Infant will not miss any appointments due to a lack of transportation	
Other:		

We the undersigned have reviewed the initial assessment and have participated in the above described plan. We concur with the number of visits to implement the interventions.
Estimated Number of Visits By: _____RN _____SW _____RD

RN Signature	Date	SW Signature	Date	RD Signature	Date

Care Plan Update

We the undersigned have reviewed the care plan update and agreed to the changes in the above described plan. We concur with the number of visits to achieve the specific objectives.
Estimated Number of Visits By: _____RN _____SW _____RD

RN Signature	Date	SW Signature	Date	RD Signature	Date

MATERNAL AND INFANT SUPPORT SERVICES PROGRAM
PROFESSIONAL VISIT PROGRESS NOTE

Beneficiary ID #: _____

Beneficiary Information

Name: _____

Parent/ Guardian: _____

Type of Visit: ☐ MSS ☐ ISS

Location of Visit: ☐ Home ☐ Office ☐ Other

Date of Visit: _____

Insurance Information

Medicaid Number: _____

Any Changes in Medicaid? ☐ YES ☐ NO

Managed Care: ☐ YES ☐ NO

If yes, Name and ID#: _____

Purpose of visit (per care plan)

#1 Problem/Needs Addressed:

Interventions Provided:

#2 Problem/Needs Addressed

Interventions Provided

Beneficiary's Name: _____

MATERNAL AND INFANT SUPPORT SERVICES PROGRAM
PROFESSIONAL VISIT PROGRESS NOTE

Follow-Up Plan Next Steps

Family Planning Issues:

Immunization Issues:

CBE/PE Issues:

Last Medical Care Provider Visit: _____

Next Medical Care Provider Visit: _____

Date of Next Visit by MSS/ISS Provider: _____

Referrals Needed:
Referrals Made:
Care Plan Update Needed ☐ Yes ☐ No

Signature Date

MATERNAL SUPPORT SERVICES (MSS)
DISCHARGE SUMMARY

Beneficiary's Name:_____ **Date of Birth:**_____
Current Address:_____
Referral Source (Agency/Program/Prenatal Care Provider):_____
Reason for Referral (High-Risk Criteria):_____
Date of Initial Assessment: _____
Sent to Medical Care Provider ☐**Yes** ☐**No**
Total Number of Visits By: ___**RN** ___**SW** ___**RD**

Summary of MSS Plan of Care Problems/Issues Addressed:

HEALTH INFORMATION

MATERNAL HEALTH

- ☐ Lack of prenatal care
- ☐ Difficulties with access to prenatal care provider
- ☐ Unsatisfied with health care
- ☐ Current health problem(s)_____
- ☐ Problems with previous pregnancies
- ☐ Lack of family planning
- ☐ Lack of dental care
- ☐ Unmet needs _____
  _____

SMOKING

- ☐ Smoked during pregnancy
- ☐ Continues to smoke
- ☐ Unmet needs _____
  _____

IMMUNIZATION

- ☐ Mom: Not up to date
- ☐ Preschooler(s): Not up to date
- ☐ Exposure to _____
- ☐ Unmet needs _____
  _____

NUTRITION

- ☐ Pre-pregnancy overweight/obesity
- ☐ Inappropriate weight gain
- ☐ Gastrointestinal problems
- ☐ Inappropriate eating patterns
- ☐ Inadequate food supply
- ☐ Lack of prenatal vitamins
- ☐ Difficulty with breast-feeding
- ☐ Unmet needs _____
  _____

SEXUALLY TRANSMITTED INFECTIONS

- ☐ At risk for sexually transmitted infection(s)
- ☐ Positive test for sexually transmitted infection(s) during this pregnancy
- ☐ Unmet needs _____
  _____

Beneficiary's Name: _____

MATERNAL SUPPORT SERVICES (MSS)
DISCHARGE SUMMARY

EMOTIONAL/MENTAL HEALTH INFORMATION

EMOTIONAL/MENTAL STRESSOR

- ☐ Lack of knowledge about pregnancy
- ☐ Lack of acceptance
- ☐ Lack of father involvement
- ☐ Lack of social support
- ☐ Unusual stressors
- ☐ Inadequate coping skills
- ☐ Symptoms of depression
- ☐ Diagnosis of mental illness
- ☐ Children's Protective Services involvement
- ☐ Indicator(s) of domestic violence
- ☐ Unmet needs _____
  _____

ALCOHOL/DRUG USE

- ☐ Alcohol use during pregnancy
- ☐ Prescription drug use
- ☐ Street drug use
- ☐ Arrested during pregnancy
- ☐ Unmet needs _____
  _____

ENVIRONMENTAL INFORMATION

- ☐ Unsafe or inadequate housing
- ☐ Exposure to toxic substance such as:
  ☐ lead ☐ asbestos ☐ pesticides ☐ cleaners ☐ other _____
- ☐ Exposure to allergens
- ☐ No smoke detectors
- ☐ Second-hand smoke
- ☐ Presence of weapons
- ☐ Frequent moves
- ☐ Problems with money management
- ☐ Lack of proper car seat
- ☐ Unsafe sleeping arrangements
- ☐ Inadequate baby supplies
- ☐ Unmet needs _____
  _____

CHILDBIRTH EDUCATION

- ☐ Lack of childbirth education
- ☐ Unmet needs _____
  _____

TRANSPORTATION

- ☐ Lack of transportation
- ☐ Unmet needs _____
  _____

OTHER: _____

_____

_____

REFERRALS MADE: _____

_____

_____

Signature of MSS Care Coordinator: _____ **Date:** _____

INFANT SUPPORT SERVICES (ISS)
DISCHARGE SUMMARY

Infant's Name:_____ **Date of Birth:**_____
Mother's Name:_____
Caregiver's Name:_____
Referral Source (Agency/Program/Medical Care Provider):_____
Reason for Referral (High Risk Criteria):_____
Date of Initial Assessment: _____
Sent to Medical Care Provider ☐**Yes** ☐**No**
Total Number of Visits By: ___**RN** ___**SW** ___**RD**

Summary of ISS Plan of Care Problems/Issues Addressed:

HEALTH INFORMATION

INFANT

- ☐ Premature birth
- ☐ Low birth weight
- ☐ Difficulties with access to medical care provider
- ☐ Well child visits
- ☐ Hospital admissions
- ☐ Special needs
- ☐ Unsatisfied with health care
- ☐ Unmet needs _____ _____

MOTHER

- ☐ Lack of prenatal care
- ☐ No postpartum visits
- ☐ Problems with previous pregnancies
- ☐ Lack of family planning
- ☐ Lack of dental care
- ☐ Unmet needs _____ _____

SMOKING

- ☐ Smoked during pregnancy
- ☐ Continues to smoke
- ☐ Unmet needs _____ _____

IMMUNIZATION

- ☐ Infant: Up to date
- ☐ Preschooler(s): Up to date
- ☐ Exposure to _____
- ☐ Unmet needs _____ _____

INFANT'S NUTRITION

- ☐ Insufficient weight gain
- ☐ Difficulties with breast-feeding
- ☐ Difficulties with bottle feeding
- ☐ Inappropriate eating patterns
- ☐ Digestive problems
- ☐ Inadequate baby formula/food
- ☐ Unmet needs _____ _____

. MOTHER'S/CAREGIVER'S NUTRITION

- ☐ Inappropriate eating patterns
- ☐ Inadequate food supply
- ☐ Unmet needs _____ _____

Infant's Name: _____

INFANT SUPPORT SERVICES (ISS)
DISCHARGE SUMMARY

EMOTIONAL/MENTAL HEALTH INFORMATION

- ☐ Lack of knowledge about infant care
- ☐ Lack of acceptance of this pregnancy
- ☐ Lack of father involvement
- ☐ Lack of social supports
- ☐ Lack of child care
- ☐ Children's Protective Services involvement
- ☐ Unusual stressors
- ☐ Unmet needs _____
  _____
- ☐ Lack of coping skills
- ☐ Symptoms of depression
- ☐ Diagnosis of mental illness
- ☐ Indicators of domestic violence
- ☐ Ineffective parent-child interaction
- ☐ Lag in developmental milestones

ENVIRONMENTAL INFORMATION

- ☐ Unsafe or inadequate housing
- ☐ Exposure to toxic substance such as:
  ☐ lead ☐ asbestos ☐ pesticides ☐ cleaners ☐ other _____
- ☐ Exposure to allergens
- ☐ No smoke detector
- ☐ Second-hand smoke
- ☐ Presence of weapon(s)
- ☐ Frequent moves
- ☐ Problems with money management
- ☐ Lack of proper car seat
- ☐ Unsafe sleeping arrangements
- ☐ Inadequate baby supplies
- ☐ Unmet needs _____
  _____

PARENTING EDUCATION

- ☐ Lack of parenting education
- ☐ Unmet needs _____
  _____

TRANSPORTATION

- ☐ Lack of transportation
- ☐ Unmet needs _____
  _____

OTHER: _____
_____
_____

REFERRALS MADE: _____
_____
_____

Signature of ISS Care Coordinator: _____ **Date:** _____