Michigan Department of Health and Human Services

Maternal Infant Health Program
Maternal Risk Identifier

1 BASICS/DEMOGRAPHICS

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

IDENTIFICATION

First Name	Middle Initial	Last Name

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

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

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

How many grades of school have you completed?

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

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

2 HEALTH HISTORY/RISKS

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

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

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

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

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

☐ YES ☐ NO ☐ DON'T KNOW ☐ REFUSED

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

What is your height without shoes? Feet [ ] Inches [ ] ☐ REFUSED

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

☐ 1 Time (First Pregnancy) [ ] Times ☐ REFUSED

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

(Approximate if necessary)

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

☐ REFUSED

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

High blood pressure (hypertension)? ☐ Yes ☐ No (If No, go to next box.)

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

Do you have another visit scheduled? ☐ Yes ☐ No

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

Comments:

Anemia or sickle cell disease? ☐ Yes ☐ No (If No, go to next box).

Have you ever had a blood transfusion for this problem? ☐ Yes ☐ No Last Date MM/YYYY

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

Do you have another visit scheduled? ☐ Yes ☐ No

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

Comments:

Diabetes or high blood sugar? ☐ *Yes ☐ No (If No, go to next box.)

Is it Insulin dependent? ☐ Yes ☐ No

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

Do you have another visit scheduled? ☐ Yes ☐ No

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

Comments:

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

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

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

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

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

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

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

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

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

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

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

3 PRENATAL CARE

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

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

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

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

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

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

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

4 SMOKING

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

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

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

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

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

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

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

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

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

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

If still smoking:

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

5 ALCOHOL

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

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

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

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

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

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

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

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

If still drinking alcohol:

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

6 DRUG USE

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

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

What did you use? (check all that apply)

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

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

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

If still using drugs:

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

7 STRESS

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

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

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

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

8 DEPRESSION AND MENTAL HEALTH

Have you ever been treated for or told that you have depression, bipolar disorder, anxiety, schizophrenia or any other mental health problem? ☐ *Yes ☐ No

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

Do you have another visit scheduled? ☐ Yes ☐ No

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

DEPRESSION FOLLOW-UP SCREENING

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

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

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

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

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

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

Things have been getting the best of me

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

I have been so unhappy that I have had difficulty sleeping

- ☐ Yes, most of the time
- ☐ Yes, sometimes
- ☐ Not very often
- ☐ No, not at all

I have felt sad or miserable

- ☐ Yes, most of the time
- ☐ Yes, quite often
- ☐ Not very often
- ☐ No, not at all

I have been so unhappy that I have been crying

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

The thought of harming myself has occurred to me

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

9 SOCIAL SUPPORT

Would you describe the father of this baby as:

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

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

☐ Yes ☐ *No

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

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

10 ABUSE/VIOLENCE

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

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

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

Specify _____

How many times has this happened? _____ times

Since you have been pregnant, have you been hit, slapped, kicked or otherwise physically hurt by someone?
☐ *Yes ☐ No

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

How many times has this happened? _____ times

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

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

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

Has your partner or someone else now in your life:

☐ *Called you names, humiliated you, or made you feel that you don't count?
☐ *Kept you from seeing or talking to your family, friends, or other people?
☐ *Thrown away or destroyed your belongings, threatened pets, or done other things to bully or scare you?
☐ *Controlled your use of money, your access to money or your ability to work?
☐ None of the Above

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

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

How many times has this happened? _____ times

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

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

11 BASIC NEEDS

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

How often did this happen? ☐ Almost every month ☐ Some months but not every month
☐ In only 1 or 2 months

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

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

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

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

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

Safety
☐ Safety of house/apartment
☐ Safety of neighborhood

How often do you have access to a telephone to make and receive calls where you live?
☐ Always ☐ Sometimes ☐ Never

12 BREASTFEEDING

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

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

CERTIFICATION

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

The MSA-1200 must be used by Medicaid enrolled Maternal Infant Health Program providers. The form must be completed and entered into the electronic format prior to billing Medicaid. Fill in enabled copies of this form can be downloaded from the MDHHS website www.michigan.gov/medicaidproviders >>Policy and Forms. The form is generally self-explanatory. Completion of the form is mandatory.

Screener Comments:

MIHP Maternal Risk Identifier Form completed by:

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