DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-01105 (07/2024)

STATE OF WISCONSIN
Wis. Admin. Code § DHS 107.34(1)(c)

FORWARDHEALTH

PRENATAL CARE COORDINATION PREGNANCY QUESTIONNAIRE

INSTRUCTIONS: Type or print clearly. Before completing this form, read the Prenatal Care Coordination Pregnancy Questionnaire Instructions, F-01105A. Providers may refer to the Forms page of the ForwardHealth Portal at www.forwardhealth.wi.gov/WIPortal/Subsystem/Publications/ForwardHealthCommunications.aspx?panel=Forms for the completion instructions.

The use of this form is required. Providers are required to use this form to determine member eligibility for the prenatal care coordination (PNCC) benefit. A member is eligible for PNCC services if they either 1) have four or more identified risk factors below or 2) are less than 18 years old (regardless of the number of risk factors identified). Questions that indicate risk factors are marked with an asterisk (*). If a risk factor applies, providers should check the box next to the asterisk. For eligible members, the questionnaire will be used to inform the care plan.

SECTION I – GENERAL INFORMATION

1. Name – Member (Last, First, Middle Initial)

2. Address – Member (Street, City, State, Zip Code)

3. County

4. Primary Phone Number – Member

5. Email – Member

6. What is the best way to contact the member? When is the best time to contact the member?

7. Member ID Number

8. Date of Birth – Member

* ❑ 9. Age – Member

* ❑ 10. What ethnicity does the member identify as?

- ❑ Hispanic
- ❑ Non-Hispanic

* ❑ 11. What race does the member identify as? (Check **all** that apply.)

- ❑ American Indian / Alaska Native
- ❑ Asian
- ❑ Black / African American
- ❑ Hawaiian / Pacific Islander
- ❑ White
- ❑ Other: _____

* ❑ 12. Education (Check highest grade completed.)

- ❑ Did not complete high school
- ❑ Completed high school (grades 1-12) or equivalent (For example, GED diploma)
- ❑ Received college degree (Associate's, Bachelor's, or Master's Degree)

* ❑ 13. Marital Status

- ❑ Married
- ❑ Not married

14. Name – Emergency Contact	15. Phone number – Emergency Contact

SECTION II – CURRENT PREGNANCY

1. Is the member pregnant with more than one baby (for example, twins or triplets)?
   ❑ Yes ❑ No

2. When is the member's due date?

* ❑ 3. When was the member's first **medical** appointment related to their current pregnancy (for example, a primary care or OB/GYN appointment)?

- ❑ _____ (Month/Year)
- ❑ The member has not had an appointment yet but has one scheduled on: _____ (MM/DD/CCYY).
- ❑ The member has not had an appointment and does not have one scheduled.

* ❑ 4. Is the member receiving nutrition services from the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)?
   ❑ Yes ❑ No

* ❑ 5. Record the member's height and weight.

Member's weight before pregnancy: _____

Member's current weight: _____

Member's height: _____

6. What is going well in the member's pregnancy so far (For example, medically, emotionally, or socially)?

7. What are the member's goals for this pregnancy (For example, nutritional goals, habit goals, or emotional goals)?

* ❑ 8. If the member could change the timing of this pregnancy, would it be earlier, later, or no change, or would the member prefer to not be pregnant at all?

- ❑ Earlier (For example, member has been trying to get pregnant for a long time)
- ❑ Later
- ❑ No change
- ❑ No pregnancy at all

9. Is the member planning to breastfeed their baby?

- ❑ Yes
- ❑ No
- ❑ Undecided

10. What does the member know about breastfeeding? What are their thoughts about or experiences with breastfeeding?

11. Has the member had any bleeding or cramping during this pregnancy? ❑ Yes ❑ No

SECTION III – PREGNANCY HISTORY (If this is the member's first pregnancy, skip to Section IV.)

1. Has the member ever been pregnant before?
   ❑ Yes ❑ No

2. How many children does the member currently have in their care, including children they have given birth to or adopted?

3. How many living children has the member given birth to?

4. How many of the member's births were full-term live births (**not** premature delivery)?

* ❑ 5. How many of the member's births were more than three weeks early (premature delivery)?

* ❑ 6. How many times has the member had a miscarriage or lost a pregnancy at 20 weeks or later?

* ❑ 7. How many times has the member had a miscarriage or lost a pregnancy before 20 weeks (including planned and unplanned end of pregnancy)?

* ❑ 8. How many babies has the member given birth to that weighed 5.5 pounds or less at birth?

9. How many babies has the member given birth to that weighed more than 9 pounds at birth?

* ❑ 10. How long has it been since the member's last pregnancy? Enter the date their last pregnancy ended.

11. What was the outcome of the member's last pregnancy?

❑ Live Birth

❑ Miscarriage or Other Loss

SECTION IV – HEALTH INFORMATION

Health and Dental Conditions

1. Does the member have a primary care physician (PCP)? ❑ Yes ❑ No

If yes, enter the provider's name and contact information below (if available).

* ❑ 2. Check all conditions that the member has or has ever had that have required ongoing medical care. Check all that apply.

❑ Asthma

❑ Chlamydia, Gonorrhea, Syphilis, or Genital Herpes

❑ Diabetes (Type ____)

❑ High Blood Pressure / Hypertension

❑ Seizures or Epilepsy

❑ Urinary Tract Infection

❑ Other Illness, Infection, or Condition Requiring Ongoing Medical Care

3. Has the member been screened for sexually transmitted infections (STIs), including HIV and syphilis, during this pregnancy? ❑ Yes ❑ No

* ❑ 4. How many times has the member been to a dentist or dental clinic in the last two years?

Does the member have painful or loose teeth, bleeding gums, or a bad taste or smell in their mouth? ❑ Yes ❑ No

Mental Health and Substance Use

5. Did the member use tobacco products (including cigarettes or e-cigarettes) before this pregnancy?

❑ Yes ❑ No

If yes, record what tobacco products the member used.

* ❑ 6. Has the member used tobacco products (including cigarettes or e-cigarettes) during this pregnancy?

❑ Yes ❑ No

If yes, record what tobacco products the member used.

7. Does anyone in the member's household smoke or use tobacco products?

❑ Yes ❑ No

8. Did the member drink alcohol in the three months before their current pregnancy?

❑ Yes ❑ No

If yes, about how many drinks did they have per week?

* ❑ 9. Has the member drunk alcohol during this pregnancy?

❑ Yes ❑ No

If yes, about how many drinks do they have per week?

* ❑ 10. In the past year, has the member used drugs that weren't prescribed to them or used drugs in a way other than how they were prescribed?

❑ Yes ❑ No

* ❑ 11. During the past month, has the member lost interest in doing things or been bothered by feeling down, depressed, or hopeless?

❑ Yes ❑ No

* ❑ 12. How does the member rate their current stress level?

❑ High ❑ Medium ❑ Low

* ❑ 13. Does the member have concerns about their mental health or substance use? ❑ Yes ❑ No

(Optional) If yes, describe the concerns.

Environmental and Social Factors

* ❑ 14. Has the member had any housing concerns in the past three months?

❑ Yes ❑ No

* ❑ 15. Does the member feel safe where they live?

❑ Yes ❑ No

* ❑ 16. In the past month, has the member had to skip any meals, not eaten when they were hungry, or used a food pantry because they did not have enough money for food?

❑ Yes ❑ No

* ❑ 17. Does the member have any problems that stop them from getting to their health care or social services appointments (for example, problems with transportation or with getting childcare)?

❑ Yes ❑ No

* ❑ 18. Has the member ever been physically, sexually, emotionally, or verbally abused by their current partner, an ex-partner, or anyone close to them?

❑ Yes ❑ No

* ❑ 19. Does the member have people in their life that they can count on when they need help?

❑ Yes ❑ No

20. Who can the member count on for help with everyday activities like childcare, cooking, laundry, or transportation?

Member Needs

21. Is the member very worried about any of the following? Check all that apply.

- ❑ Money problems
- ❑ Their own job, unemployment, or education
- ❑ Their partner's job or unemployment
- ❑ Their own drinking or substance use
- ❑ Drinking or substance use by someone else in their household
- ❑ Their relationship with their partner
- ❑ Their partner didn't want this pregnancy
- ❑ Labor and delivery
- ❑ Caring for this baby
- ❑ Caring for their other children
- ❑ Stable housing / food
- ❑ Difficulty accessing medical or social service support
- ❑ Social and community network
- ❑ Access to transportation
- ❑ Other: _____

22. Which concern from Element 21 is the member **most** worried about?

23. How does the member cope with their problems, and how has the member overcome problems in the past?

24. What topics would the member like to learn more about? Check all that apply.

- ❑ Alcohol's effect on their health and their baby's health
- ❑ Baby growth and development
- ❑ Breastfeeding
- ❑ Caring for their newborn
- ❑ Family planning and birth control
- ❑ Getting health care for themselves or their baby
- ❑ How to stop using tobacco products
- ❑ How to be more comfortable during the pregnancy
- ❑ Labor and delivery
- ❑ Nutrition during and after the pregnancy
- ❑ Managing stress
- ❑ Other: _____

25. Additional Information

SECTION V – ELIGIBILITY AND SIGNATURE (To be completed by PNCC agency care coordinator, qualified professional reviewer, and member.)

* ❑ 1. Is the member fluent in and comfortable with English? ❑ Yes ❑ No

2. Is the member eligible for PNCC services? If yes, why?

❑ Yes, because:

❑ They have four or more risk factors. Their total number of risk factors is: _____.

❑ They are ___ years old.

❑ No

3. Name – Care Coordinator Completing Questionnaire

4. **SIGNATURE** – Care Coordinator	5. Date Signed – Care Coordinator

6. Name – Qualified Health Professional Reviewer (If different from above)

7. **SIGNATURE** – Qualified Health Professional Reviewer	8. Date Signed – Qualified Health Professional Reviewer
9. **SIGNATURE** – Member	10. Date Signed – Member

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