

**FORWARDHEALTH
PRENATAL CARE COORDINATION CARE PLAN**

INSTRUCTIONS: Type or print clearly. This care plan is for participation in a voluntary Medicaid benefit and must be reviewed every 60 days, or earlier if the member's needs change, and updated if necessary. However, it may be changed as often as necessary and at any time. Prenatal care coordination (PNCC) providers may use this template with a member's initial assessment on the Prenatal Care Coordination Pregnancy Questionnaire, F-01105, to develop and update a comprehensive care plan with the member. The initial assessment can be completed on the same date of service as the care plan, but the initial assessment must be completed first, and the care plan should be completed based on the needs identified in the initial assessment.

Providers are required to tell members how they can request changes to the care plan and give them the name, phone number, and email of the person to contact to make changes. This care plan can also be used to document if services are reduced, transferred, or ended.

Note: This care plan does not replace the need for a consent document to release member information. For more information about consent requirements, care plan requirements, and requirements for the initial assessment, refer to the Key Prenatal Care Coordination Requirements section of the Prenatal Care Coordination service area of the ForwardHealth Online Handbook at <https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Display.aspx?ia=1&p=1&sa=54>.

SECTION I – MEMBER AND PROVIDER INFORMATION

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

2. Name – PNCC Provider's Qualified Professional (Last, First, Middle Initial)

3. Name – Agency

4. Member Medicaid ID Number

SECTION II – STRENGTH-BASED ASSESSMENTS

5. Indicate the member's strengths and abilities.

- ☐ Ability to Meet Personal Goals
 - ☐ Knowledge or Education
 - ☐ Life Experience
 - ☐ Love for Child or Children
 - ☐ Love for Self
 - ☐ Motivation/Determination/Follow-Through
 - ☐ Personal Relationships
 - ☐ Positive Attitude
 - ☐ Religious Beliefs or Spiritual Practice
 - ☐ Resourcefulness
 - ☐ Sense of Humor
 - ☐ Other (Specify)
-

SECTION III – HEALTH INFORMATION FROM INITIAL ASSESSMENT

6. List the risk factors or needs and concerns from the initial assessment.

7. Indicate the member's primary needs and concerns regarding mental health.

- ☐ Concerns About Pregnancy
- ☐ Drugs, Alcohol, or Tobacco Use
- ☐ Mental Health Concerns
- ☐ Pregnancy History
- ☐ Support System
- ☐ Religious, Ethnic, or Cultural Factor Affecting Pregnancy
- ☐ Not Applicable
- ☐ Other (Specify)

8. Indicate the member's primary needs and concerns during and after pregnancy.

- ☐ Child Care Needs
 - ☐ Child Support Difficulty
 - ☐ Conflict or Violence in the Home
 - ☐ Difficulty Enrolling in Women, Infants, and Children Supplemental Nutrition Program (WIC)
 - ☐ Difficulty Obtaining FoodShare
 - ☐ Employment Needs
 - ☐ Funds or Food
 - ☐ Health Needs
 - ☐ Housing Needs
 - ☐ Medical Health Needs/Concerns
 - ☐ Prenatal/Postpartum Care
 - ☐ School Needs
 - ☐ Transportation Needs
 - ☐ Not applicable
 - ☐ Other (Specify)
-

SECTION IV – RELATIONSHIPS AND SOCIAL SUPPORT

9. Indicate the people who can help the member meet their care plan goals.

- | | |
|--|--|
| <input type="checkbox"/> Partner or Spouse | <input type="checkbox"/> Extended Family |
| <input type="checkbox"/> Parents | <input type="checkbox"/> Home Visitors |
| <input type="checkbox"/> Siblings | <input type="checkbox"/> Other (Explain) _____ |
| <input type="checkbox"/> Friends | _____ |
-

10. List the member's collateral contacts and their contact information.

- a. _____
- b. _____
- c. _____
-

11. List other providers working with the member, their roles, and their contact information.

- a. _____
- b. _____
- c. _____
-

12. Does the member want to strengthen their relationships and social supports? ☐ Yes ☐ No

If yes, describe the plan to strengthen their relationships and social supports.

SECTION V – CARE PLAN

- ☐ Initial Care Plan
- ☐ Updated Care Plan

If the care plan is being updated, briefly describe the reason for the update.

Need Identified in the Assessment	Client Desire to Address	Action Steps	Frequency of Service	Goals and Outcomes
	<input type="checkbox"/> Yes <input type="checkbox"/> No			

Need Identified in the Assessment	Client Desire to Address	Action Steps	Frequency of Service	Goals and Outcomes
	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	<input type="checkbox"/> Yes <input type="checkbox"/> No			

SECTION VI – POSTPARTUM CARE CHECKLIST

Indicate the date for each event.

Pregnancy Ended _____

First Postpartum Visit _____

Postpartum/WIC Certification _____

Infant Certified for WIC _____

Last Date of PNCC Services _____

SECTION VII – POSTPARTUM CARE PLAN

Need Identified in the Assessment	Client Desire to Address	Infant Age	Action Steps	Frequency of Service	Goals and Outcomes
	<input type="checkbox"/> Yes <input type="checkbox"/> No				
	<input type="checkbox"/> Yes <input type="checkbox"/> No				
	<input type="checkbox"/> Yes <input type="checkbox"/> No				

Need Identified in the Assessment	Client Desire to Address	Infant Age	Action Steps	Frequency of Service	Goals and Outcomes
	<input type="checkbox"/> Yes <input type="checkbox"/> No				
	<input type="checkbox"/> Yes <input type="checkbox"/> No				
	<input type="checkbox"/> Yes <input type="checkbox"/> No				
	<input type="checkbox"/> Yes <input type="checkbox"/> No				

SECTION VIII – SERVICE CHANGES

☐ PNCC services have been ended.

Describe reason for ending services.

If the member has switched PNCC providers, list the name of the new service provider.

SECTION IX – SIGNATURE

The qualified professional must sign this form if it is an initial care plan.

SIGNATURE – PNCC Provider's Qualified Professional

Date Signed – PNCC Provider's Qualified Professional

Print Name – PNCC Provider's Qualified Professional

SIGNATURE – Member

Date Signed – Member

Print Name – Member
