1. Last Name	First Name	MI

2. Patient Number	☐☐☐☐☐☐☐☐☐ - H
3. Date of Birth	☐☐ Month ☐☐ Day ☐☐☐☐ Year
4. Race: 1 = White 2 = Black 3 = Am. Ind. / Alaskan Native 4 = Asian / Pacific Islander	☐
5. Ethnicity: Hispanic Origin? 1 = Yes 2 = No	☐

6. Special Populations:			
Migrant Farmworker/Dependent? Y/N	☐	Country of Origin:	☐
Seasonal Farmworker/Dependent? Y/N	☐	1 = Mexico	
English Speaking? Y/N	☐	2 = Haiti	
Homeless? Y/N	☐	9 = Other - All others including USA	
Refugee? Y/N	☐		

7. 1 = Male 2 = Female	☐
8. County of Residence	☐☐☐

MATERNITY CARE COORDINATION

Letter of Agreement

The Baby Love–Medical Assistance Program wants you to have a healthy baby. Your Maternity Care Coordinator (MCC) can help you find and get the services you need. Your MCC can provide you with information about:

medical benefits
prenatal care
WIC services
transportation
information about pregnancy
information about other services

Your MCC is there to help you!

Your part in care coordination services is to:

get prenatal care and WIC as soon as possible
keep all appointments
tell your MCC about your needs during pregnancy
let your MCC know how and where you would like to be contacted
do your best to follow your plan for having a healthy baby

Both the MCC and the client must agree to sign this letter of agreement to begin maternity care coordination services.

I understand my part and wish to get maternity care coordination services. Prenatal care and other Medicaid benefits will not stop if I choose not to get care coordination services.

Name of Client _____ Date _____

I understand my part of care coordination services and will work with the client to help her receive the services she needs.

Maternity Care Coordinator _____ Date _____

Backup MCC _____ Date _____

Maternity Care Coordinator's Phone Number _____

DMA–3004 Rev 10–99
PS-00255

White: Provider Copy
Pink: Client Copy