PROBLEM PREGNANCY SERVICES - APPLICATION FOR STATE MATERNITY FUNDS
CLIENT HISTORY & SERVICE PLAN

Today's Date:

Complete application using the TAB key to move between fields

Application can only be submitted by a NC Local Department of Social Services or NC License Adoption Agency.
Caseworker will be responsible for development and oversite for all components of the service plan represented by this application.

1. SUPPORTING AGENCY and CASEWORKER INFORMATION

A. Supporting Agency's Name

B. Caseworker's Name

C. Caseworker's Phone Number w/ area code
( ) - Extension

D. Caseworker's E-Mail

2. APPLICANT INFORMATION

A. Applicant's Last Name | **B. First** | **C. MI** | **D. US Citizen** | **E. Citizenship Verified by:**

F. Date of Birth | **G. Race** | **H. Ethnicity**

I. Number of Previous Pregnancies ___
Outcomes of Previous Pregnancies: Live Birth- ___
Miscarriage- ___ Abortion- ___ Other- ___

J. Marital Status | **K. Highest Grade Completed**

L. Current Living Arrangement

M. Address, City, State, Zip Include County if available
- (North Carolina Residency is Required for Funding approval)
_____ *Address*
_____ *City State & Zip*
NC County

N. Expected Delivery Date (required)

O. Actual **Admission Date** or **P.** Anticipated **Admit Date**

Q. Other People Living in Household
Name Age Relationship to applicant

R. Applicant's Present Employer

S. Applicant's Employer's Location or Address

T. Sources of Income – All income must be listed, including Employment, Social Security, Child support, etc.

Source	Details: Rate, hours, months employed, etc.	**Monthly** Gross Amount
		$
		$

U. Monthly Resources Available for Placement Costs

Applicant	Parents/Relatives	Expectant Father	Referring Agency	Others
$	$	$	$	$

COMPLETE SECTION FOR MINOR CLIENT UNDER THE AGE OF 18 (or active in *Foster Care or a FC to 21* program)
V1. Is client in the legal or contractual responsibility of DSS? YES ☐ If so, provide County: _____
V2. Information for the LEGAL Parent or Guardian for a minor client - *(Legal Guardian Must also sign Application)*

Parent or Guardian's Last Name	First	MI	Additional notes about family structure
Present Employer	Employer Address		**Monthly** Gross Amount $

W. Father of the unborn child

Last Name	First	MI	Provide any details on his involvement and ability to provide support: _____

3. PROBLEM ASSESSMENT AND SERVICE PLAN, Completed by Case Worker based on Service Plan Development with client

A1. Is this a high-risk pregnancy due to physical issues? YES ☐ If so, explain. _____
A2. Is there a history of drug abuse, incarceration, child protective services (as a youth or as an adult), extended homelessness, and/or mental health issues? YES ☐ If so, provide basic details and dates if available. _____

B1. Does the client intend to parent or place child for adoption? _____
B2. If she intends to parent, what are the current plans for herself, her child, and any additional family members after delivery? _____

C. Describe her family/friends/support system. _____

D. Why is this residential placement being considered? _____

E1. What efforts have been, or are being made, to help her receive needed services and support locally so that a residential placement might be avoided? _____
E2. Has the client contacted other agencies for assistance? YES ☐ NO ☐
If so, list agency and approximate date contacted: _____

F. Has she received SMF previously? YES ☐ If so, describe the placement including the residential setting, the year of entry, and the outcome for her and the child. _____

G. Service Plan for Applicant and Child

Service	Currently Provided -List Agency	Planned -List Agency	Not Needed	Refused
Education				
Emotional Support/Counseling				
Employment and Training				
Family Planning				
Food and Nutritional Services *(must suspend upon approval)*				
Housing Following Delivery				
Income Assistance Received				
Parenting Education				
WIC or another Nutritional Plan				
Other				

3. PROBLEM ASSESSMENT AND SERVICE PLAN, continued
Completed by Case Worker based on Service Plan Development with client

H1. How often will referring agency have contact with the client to support this Service Plan and method (face to face, telephone, etc.? _____

H1. How will referring agency support this Service Plan? _____

I. How does the service plan promote sexual responsibility to avoid future unplanned pregnancies? _____

4. RECOMMENDED PROVIDER FOR CARE PLAN

A. Proposed Living Arrangement

☐ Licensed Maternity Home: Name

*Alternative Living Arrangement / Private Provider **(must be pre-approved)**

☐ Boarding Arrangement ☐ Licensed Foster Home ☐ Home of Non-Legally Responsible Relative

When a client is requesting an Alternative Living Arrangement that is not an approved licensed family foster home, the DSS 6189 form must be completed and attached. *Form available online:* *https://policies.ncdhhs.gov/divisional/social-services/forms/dss-6189-state-maternity-fund-residential-care-provider-agreement/@@display-file/form_file/dss-6189-ia.pdf*

B. Explain how this placement is the least restrictive as well as the most cost-efficient placement possible for this applicant. _____

C. Current Medical Care Provider and location:

5. CERTIFICATION

I certify the information I have given is accurate and complete to the best of my knowledge. I understand that ALL information is subject to verification.

A. Applicant Signature *Contact Phone Number* _____	B. Date
C. Parent Signature (If Applicant is a Minor)	D. Date
E. Caseworker Signature	F. Date

Signed application can be e-mail directly to the State Maternity Fund Coordinator: Amy.Oathout@dhhs.nc.gov
Or mailed to: NC Division of Social Services, Child Welfare Services, PO Box 187, Apex, NC 27502

Pregnancy Services Program information is available on-line at:
https://policies.ncdhhs.gov/document/appendix-4-pregnancy-services/
If additional information is needed, call (984) 314-6779