CARE COORDINATION RECORD

A. 1. Mother's 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

Ethnicity: Hispanic Origin? 1 = Yes 2 = No

5. 1 = Male 2 = Female

6. County of Residence

B. Mother's
1. Medicaid No.

2. Blue (Regular Medicaid) ☐
Pink (Special Medicaid) ☐
PE ☐ Yes ☐ No

3. Date Medicaid Application Ruled Ineligible ____/____/____

Reason ______

Caseworker ______

	Dates Began	Dates Ended
4. Presumptive Eligibility Period		
5. Medicaid Certification		
6. WIC Certification		

C.

1. * Parent/Caregiver ______
2. Address ______
3. Phone ______ Home ______ Work
4. Employer ______
5. School ______
6. Care Coordination Agency ______
7. Other Contact ______ Phone # ______
8. EDC ______
9. Weeks Gestation When Prenatal Care Begin ______
10. Gravida/Parity ______
11. Prenatal Care Provider ______
12. Primary Care Provider ______

D. FAMILY STRENGTHS/NEEDS ASSESSMENT

Code	Mother/Child (Circle One)	Comment	Mother/Child (Circle One)	Comment	Code
	1. Experience With Care Coordination				
	2. Concern about Pregnancy				
	3. Previous Pregnancy/Parenting Experience				
	4. Support System				
	5. Transportation				
	6. Employment				
	7. Education				
	8. Child Care				
	9. * Respite Care				
	10. Adequacy of Food Resources				
	11. WIC Participation				
	12. Breast-feeding				
	13. Adequacy of Financial Resources				
	14. Medicaid Participation				
	15. Housing				
	16. Heath Care (Mother)				
	17. Family Planning				
	18. Health Care (Child)				
	19. Health Care (Family)				
	20. * Understanding of Child's Condition				
	21. * Parent Expectation of Child				
	22. * Support Group Involvement				
	23. Religious/Ethnic/Cultural Values Affecting Care				
	24. Tobacco Usage				
	25. Drug/Alcohol Usage				
	26. Apprehension/Anxiety				
	27. Conflict/Violence in Home				
	28. Sexual Abuse				
	29.				
	30.				

Signature ______ Date ______ Signature ______ Date ______

Codes: O=no problem X=significant problem N/A=non applicable N=see notes NO=NO YES=YES

* CSC related information

DMA 3006 (Rev. 5/00)

CARE COORDINATION RECORD

E. 1. Child's 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

Ethnicity: Hispanic Origin? 1 = Yes 2 = No

5. 1 = Male 2 = Female

6. County of Residence

F. Child's
1. Medicaid No.

Blue (Regular Medicaid) ☐

2. Date Medicaid Application Ruled Ineligible ______/______/______

Reason ______________________________

Caseworker

	Dates Began	Ended
3. Medicaid Certification		
4. WIC Certification		

G. CHILD STRENGTHS/NEEDS ASSESSMENT

Code	Date / / Age Comment	Date / / Age Comment	Code
	31. Routine Health Care		
	32. Immunization		
	33. Specialized Health Care		
	34. Home Nursing Care		
	35. Medication		
	36. Equipment		
	37. Special Formula/Diet		
	38. Supplies		
	39. Understanding of child's dev.		
	40. Therapies		
	41. Preschool/Early Intervention		
	42. Education		
	43. Relationship with Siblings		
	44. Relationship with Peers/Others		
	45. Parent/Child Interaction		
	Signature	Signature	

H. MATERNITY CARE COORDINATION

Topics	Date	Signature
1. Early and Continuous Prenatal Care		
2. WIC Discussed		
3. Provision of Educational Material		
4. Childbirth Education		
5. Parenting Education		
6. Delivery plans Discussed		
7. Infant Safety Seat Discussed		
8. Family Planning Discussed		
9. Automatic Newborn Eligibility Discussed		

I. MATERNITY CARE COORDINATION CLOSURE

1. Infant's Name	
Comments (as appropriate)	Dates
2. Pregnancy Ended	
3. Postpartum Family Planning Visit	
4. Postpartum WIC Certification	
5. Infant Certified for WIC	
6. Infant Certified for Medicaid	
7. Closed for Care Coordination Referral	
8. Well Child Sceening/Provider	
9. Child Service Coordinator Referral	
10. Other Community Contacts/Referrals	
11. Client Notified MCC Services Discontinued	
12. Pregnancy Outcome Summary/Report Completed	

J. CHILD SERVICE COORDINATION TRANSITION/CLOSURE

Comments	Dates
1. Update Care Coordination Plan	
2. Refer to New CSC As Appropriate	
3. Notify Caregivers As Appropriate	
4. Intermediate Assessment	
5. Complete Status Report	
6. Document Change in CSC File	

Codes: O=no problem X=significant problem N/A=non applicable N=see notes NO=NO YES=YES