**DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN**

Division of Medicaid Services

F-03183 (06/2023)

**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](https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Display.aspx?ia=1&p=1&sa=54).

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| **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) | |

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| **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) |

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| **SECTION IV – RELATIONSHIPS AND SOCIAL SUPPORT** | | | | |
| 9. Indicate the people who can help the member meet their care plan goals. | | | | |
| Partner or Spouse  Extended Family  Parents  Home Visitors  Siblings  Other (Explain)  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** |
|  | Yes  No |  |  |  |
| **Need Identified in the Assessment** | **Client Desire to Address** | **Action Steps** | **Frequency of Service** | **Goals and Outcomes** |
|  | Yes  No |  |  |  |
|  | Yes  No |  |  |  |
|  | Yes  No |  |  |  |
|  | Yes  No |  |  |  |

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| **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** |
|  | Yes  No |  |  |  |  |
|  | Yes  No |  |  |  |  |
|  | Yes  No |  |  |  |  |

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| **Need Identified in the Assessment** | **Client Desire to Address** | **Infant Age** | **Action Steps** | **Frequency of Service** | **Goals and Outcomes** |
|  | Yes  No |  |  |  |  |
|  | Yes  No |  |  |  |  |
|  | Yes  No |  |  |  |  |
|  | Yes  No |  |  |  |  |

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| **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’sQualified Professional | |
| **SIGNATURE –** Member | Date Signed **–** Member |
| Print Name –Member | |