Steps Ahead

ENROLLMENT FORM

Patient Information

Name: _____ **EDC:** _____
Last First MI

Address: _____ **City:** _____

State: _____ **Zip:** _____ **County:** _____ **Phone #:** _____

Social Security #: _____ **Birth Date (M/D/YY):** _____

Race: ☐ Caucasian ☐ Black ☐ Asian or Pacific Islander ☐ Hispanic ☐ American Native or Alaskan Native ☐ Other_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Medicaid # or Application Date/Site: _____ **Eligibility Category:** _____

Do you have other health insurance? (List even if it will not cover maternity) ☐ Yes ☐ No

Does it Cover Maternity? ☐ Yes ☐ No

Insurance Company: _____ **Policy #:** _____

Effective Date: _____ **Termination Date**: _____

Policyholder's Name: _____ **Relationship to Patient:** _____

Policyholder's Date of Birth:_____ **Policyholder's Gender**: _____

Group Name/Number: _____ **Insurance Co. Phone #:**_____

Risk Assessment

Previous Pregnancy: ☐ Yes ☐ No **Previous Fetal Loss:** ☐ Yes ☐ No **Pregnancy Planned:** ☐ Yes ☐ No

Psychological Risk at Enrollment: ☐ High ☐ Low **Medical Risk at Enrollment:** ☐ High ☐ Low

Previous Preterm Births: ☐ Yes ☐ No **Previously Enrolled in Plan?:** ☐ Yes ☐ No

Smoker or Recent Quitter (within last 2 months)?: ☐ Yes ☐ No **Smoking Cessation Form Completed?:** ☐ Yes ☐ No

Provider Selection

After looking at the current list of providers, I choose the following:

	Provider Name	DCHP ID#	Telephone #	If multiple locations, which location
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____

Appointment made? ☐ Yes ☐ No **Date and Time of Appointment:** _____(MD or CC)

Care Coordinator Name: _____ **CC #:**_____ **CC Phone #:** _____

Enroll Site: _____

Affirmations

1. I have been given a copy of the Steps Ahead Member Handbook, which contains the Rights and Duties and the Agreement to Receive Prenatal Care.
2. The Grievance and Provider Choice procedures have been explained to me.
3. **I have been given a list of Delivering Physicians and Hospitals to choose from. I made my own choice. Initial _____**
4. What to do in the case of a real emergency has also been explained to me.
5. I understand if I am not approved for Medicaid, I must make payment plans with all my healthcare providers and the hospital.
6. I give permission for the release of information for those purposes directly related to the administration of Steps Ahead Medicaid Maternity Program. These purposes include, but are not limited to, establishing eligibility for medical services and quality management. I understand that my Care Coordinator shall disclose information about my healthcare to providers for the above reasons.
7. I have had a chance to ask questions, if I did not understand, and I agree to fully participate in the Steps Ahead Program.
8. I agree to keep my Care Coordinator informed, and to keep all prenatal and Care Coordination appointments/encounters.

_____ _____ _____ _____
Enrollee Signature **Date** **Person Competing Enrollment Form** **Date**