WVCAC EARLY HEAD START

205 West Chickasha Ave. Chickasha,OK 73018
Phone: 405-224-5831 Fax: 405-222-4303
Website: www.washitavalleycommunityactioncouncil.com

Expectant Families Application

The following documents are required when filling out an application for the Pregnant Mom Program

Los siguientes documentos son requeridos al llenar una solicitud para el Programa para Madre Embarazada:

— Social Security Card / *Tarjeta del Seguro Social*

— Proof of Pregnancy with Estimated Due Date / *Prueba de embarazo con la feche de posible día de nacimiento*

— Medical Insuarance (if any) / *Seguro medico (si tienen)*

— Income Documentation (Previous year federal income tax preferred) / *Comprobantes de los Ingresos*

Please feel free to contact us with any questions. *Por favor si tiene preguntas no dude en llamarnos.*

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WVCAC
Early Head Start Expectant Families Program

EXPECTED DELIVERY DATE______________________________(OFFICE USE ONLY)

Participant

Last	First	Middle	Preferred	Suffix

Birthday	Gender	SSN	Alternate ID

Highest Grade Completed	Employment Status (use codes)	☐ Provides Financial Support ☐ Teen Parent ☐ Subsidized ☐ Military
		Marital Status: ☐ Single ☐ Married ☐ Divorced ☐Widowed

Email Address

Notes:

1. Employment Status Codes: F- Full Time, P - Part Time Work or Part Time Training, R - Retired or Disabled, T - Training or School, B - Full Time & Training, I - Part Time & Training, S - Seasonally Employed, U - Unemployed

Race *(check all that apply)*	Hispanic	English Proficiency	
☐ Asian ☐ Black ☐ White ☐ Native American ☐ Pacific Islander ☐ Other___________	☐ Yes ☐ No	☐ None ☐ Poor ☐ Moderate ☐ Proficient	☐ Primary
		Other Language Spoken ___________________ ☐ Poor ☐ Moderate ☐ Proficient	☐ Primary

Medicaid Eligibility	Medicaid Number	Primary Health Coverage	Other Health Coverage	Insurance Number

Which trimester of pregnancy are you in this time? 1st____ 2nd_____ 3rd______

When is your expected delivery date? ___________________ Have you received regular prenatal care? _____yes _____no

Are there any suspected problems? _____yes _____no If yes, please specify:

Secondary Adult Participant Spouse

Last	First	Middle	Preferred	Suffix

Birthday	Gender	SSN	Alternate ID

Highest Grade Completed	Employment Status (use codes)	☐ Lives with Child ☐ Provides Financial Support ☐ Teen Parent ☐ Subsidized ☐ Military
		Marital Status: ☐ Single ☐ Married ☐ Divorced ☐Widowed

Email Address

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General Information

Living Address	City	State	Zip	County
Mailing Address (if different)	City	State	Zip	

Phone Number	Home, Work, Cell, etc.	Primary	Notes
		☐	
		☐	
		☐	
		☐	

How did you hear about the program? ____

Signature of Staff Taking Application__________________________________ Date_____________________

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Household Information		
Number in Household:	Num. in Family:	Total Num. of Children:

List all persons living in the home: Name	Age	Relationship to Pregnant Mom

Parental Status	Primary Language at Home:	Receive SSI	Child Support Received
☐One ☐Two		☐Yes ☐No	☐Yes ☐No

TANF ☐Yes ☐No ☐Formerly	☐SNAP No. ____________________	☐WIC WIC ID __________

Certification: *I certify that this information is true. If any part is false, my participation in this agency's programs may be terminated and I may be subject to legal action. I also understand that the information in this application will be held in strict confidence within the agency and is accessible to me during normal business hours.*

Parent/Guardian Signature__________________________________ Date______________

Verifying Staff Member __________________________________ Date ______________

*Program Entry Date*__________________________

*Program Exit Date*__________________________

WASHITA VALLEY CAC EARLY HEAD START

Prenatal History

Today's Date_______________

Mother's name:

Last: ______________________________ First: ____________________ MI: ________

Do you have any medical coverage or insurance? ☐ Yes ☐ No

If yes, what type of coverage? ___ Sooner Care ___ Fee for Service/Medicaid ___ Private ___ None

Provider's Name: ____________________ ID or Policy Number: ____________________

Is dental coverage included in this policy?☐ Yes ☐ No

Name of dental plan: ____________________Date of last exam____________________

How long have you been pregnant? __________When is your expected delivery date? __________

Have you received any prenatal care? Yes No If yes, in which month of pregnancy did you first see a physician or attend a clinic for prenatal care? 1st 2nd 3rd 4th 5th 6th 7th 8th 9th ☐Don't remember

Where did you receive prenatal care? ☐Health clinic ☐Hospital ☐Enrollee's home ☐Physician
☐School-based health facility ☐other – please specify ______________________________

Who is your primary health care provider? (Regular Doctor)

Name ____ Phone ______________
Street ____ Suite ______________
City ____________________________ State _________ Zip ______________
☐No primary health care provider

Who is your primary prenatal care provider? (OB/GYN)

Name ____Phone ______________
Street ____Suite ______________
City ____________________________State _________Zip ______________
☐No primary prenatal care provider ☐ Same as primary health care provider

What is the date of your next scheduled prenatal care visit? __/__/____ ☐ No visits schedule

What is the date of your most recent prenatal care visit? __/__/____ ☐ No prenatal care visits

Have you experienced any complications during this or any previous pregnancy?

☐ No complications ☐ Yes, please explain: ____

How many times have you been pregnant prior to this pregnancy? ______

How many children have you given birth to? ______

What was the outcome of other pregnancies?

☐ Miscarriage ☐ Stillborn ☐ Abortion ☐ Decline to answer ☐ other- please specify ____________

How many children were born prematurely? _____________

How long has it been since your last pregnancy? ☐ Never been pregnant ☐ Less than 18 months

☐ More than 18 months

What medical or health services are you currently receiving?

☐ No services currently being received

Service	Since

Have your participated in any education groups for child birth or parenting during your current pregnancy?

☐ Yes ☐ No

If yes, what kinds of groups have you participated in?

☐ Prenatal exercise ☐ Preparing for baby care ☐ Personal development
☐ Prenatal general discussion ☐ Birth education (Lamaze) ☐ Parenting education
☐ Breast feeding preparation ☐ other: ________________________________

How many sessions of these groups have you attended? ☐ 1-5 ☐ 6-10 ☐ 11-20 ☐ 21-30 ☐ more than 30

Have you been visited regularly by any nurse, social worker, support person during your pregnancy?
☐Yes ☐No

If yes:

Visitor's name: ______________________________ ☐ do not know

Agency: ______________________________ ☐ do not know

How are you planning on feeding your baby?

☐ Breast ☐ Formula

Have you used any of the following substances during your pregnancy?

Street drugs ☐Yes ☐No Caffeine☐Yes ☐No Cigarettes/Tobacco☐Yes ☐No
Prescription Drugs ☐Yes ☐No Non-Prescription drugs ☐Yes☐No Alcohol ☐Yes☐No
Other (please specify)☐ Yes☐ No ______________________________

Expectant
Mother______________________________Date__________________

Staff______________________________Date__________________