MISSOURI DEPARTMENT OF SOCIAL SERVICES
MO HEALTHNET DIVISION

RISK APPRAISAL FOR PREGNANT WOMEN

INSTRUCTIONS ON REVERSE SIDE

MO HEALTHNET MANAGED CARE AGENCY NAME	AGENCY FAX NUMBER
PARTICIPANT SOCIAL SECURITY NO.	

DCN OR TEMP. NO	BIRTHDATE	DATE OF RISK APPRAISAL	PROVIDER NAME (ATTACH MO HEALTHNET LABEL)
PARTICIPANT'S NAME (LAST, FIRST, MI, MAIDEN)			PROVIDER ADDRESS (STREET)
PARTICIPANT ADDRESS (STREET)			PROVIDER CITY STATE ZIP CODE
PARTICIPANT CITY STATE ZIP CODE			MO HEALTHNET PROVIDER IDENTIFIER
TELEPHONE NUMBER	COUNTY OF RESIDENCE	MARITAL STATUS CODE ☐ S ☐ M ☐ W ☐ D ☐ SEP	PROVIDER TAXONOMY CODE

MONTH PRENATAL CARE BEGAN: ■ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9

RACE/ETHNICITY	HISPANIC ORIGIN	LMP (MM/DD/YY)	GRAVIDA	PARA	ABORTA
☐ 1. WHITE ☐ 2. BLACK ☐ 3. AM.IND/ALASKAN ☐ 4. ASIAN ☐ 5. PACIFIC ISLANDER ☐ 6. OTHER _____	☐ YES ☐ NO		1	2	0

PUT AN "X" IN ALL THE BOXES BELOW THAT APPLY. AN "X" IN ANY ONE OF THE FIRST 34 RISK FACTOR BOXES QUALIFIES CLIENT FOR CASE MANAGEMENT SERVICES.

☐ 1. Mother's age 17 years or less at time of conception
☐ 2. Mother's education less than 8 years
☐ 3. Gravida greater than or equal to 7
☐ 4. Currently smoking
☐ 5. Mother's age 35 years or greater at time of conception
☐ 6. Prepregnancy weight less than 100 lbs
☐ 7. Previous fetal death (20 weeks gestation or later)
☐ 8. Previous infant death
☐ 9. History of incompetent cervix in current or past pregnancy
☐ 10. History of diabetes mellitus including gestational diabetes in current or past pregnancy
☐ 11. Multiple fetuses in current pregnancy
☐ 12. Pre-existing hypertension (a history of hypertension — 140/90 mm Hg or greater — antedating pregnancy or discovery of hypertension — 140/90 or greater — before the 20th week of pregnancy)
☐ 13. Pregnancy-induced hypertension in current pregnancy (blood pressure is 140/90 or greater, or there has been an increase of 30 mm Hg systolic or 15 mm Hg diastolic over baseline values on at least two occasions six or more hours apart)
☐ 14. Prior low birth weight baby (<2500 grams or 5 lbs. 8 oz.)
☐ 15. Prior preterm labor (<37 completed weeks gestation)
☐ 16. Preterm labor: current pregnancy
☐ 17. Seropositive for HIV antibodies
☐ 18. Interconceptional spacing <1 year
☐ 19. Living alone or single parent living alone
☐ 20. Considered relinquishment of infant
☐ 21. Unfavorable environmental conditions
☐ 22. Late entry into care (after 4th month or 18 weeks gestation)
☐ 23. Homelessness
☐ 24. Alcohol abuse by participant
☐ 25. Alcohol abuse by partner
☐ 26. Drug dependence or misuse by participant
☐ 27. Drug dependence or misuse by partner
☐ 28. Physical or emotional abuse/neglect of participant
☐ 29. Physical abuse of children in the home
☐ 30. Neglect of children in the home
☐ 31. Partner with history of violence
☐ 32. Chronic or recent mental illness and/or psychiatric treatment
☐ 33. Elevated blood lead level 15-19ug/dl or greater
☐ 34. Other, identify:

☐ 99. None of the above

FOLLOWING DOES NOT QUALIFY FOR CASE MANAGEMENT SERVICES. DATA COLLECTION IS NECESSARY FOR PROGRAM PLANNING. (CHECK ONE)

☐ 1. Intended pregnancy
☐ 2. Unintended pregnancy using birth control
☐ 3. Unintended pregnancy not using birth control
☐ 4. Unintended pregnancy - birth control unknown

SPECIFY GESTATIONAL AGE AT TIME OF RISK APPRAISAL: WEEKS	APPROXIMATE DUE DATE MM DD YY	PHYSICIAN'S MO HEALTHNET PROVIDER IDENTIFIER
PROVIDER SIGNATURE	DATE	PROVIDER TAXONOMY CODE
PREFERRED CASE MANAGEMENT PROVIDER AGENCY		

Risk Appraisal Form for Pregnant Women

Purpose:

To document the appraisal "at risk conditions for determining participant's eligibility for MO HealthNet Case Management Services.

Distribution:

Preferred Case Management Provider

Instructions:

MO HealthNet Managed Care Agency Name — Enter name of participant's enrolled MO HealthNet Managed Care agency.

Agency Fax Number – Enter the MO HealthNet Managed Care agency's fax number.

SSN — Enter the 9 digit number assigned by Federal Government.

DCN — Enter the 8 digit number assigned to eligible MO HealthNet participants.

Birth Date — Enter the participant's birth date as it is shown on the MO HealthNet card (Use MM/DD/YY format).

Date of Risk Appraisal— Enter date the Risk Appraisal was conducted (Use MM/DD/YY format).

Provider Name — Print or type provider name of the Agency completing the Risk Appraisal (or attach MO HealthNet Provider Label to each copy).

Participant's Name — Enter last name, first name, middle initial, and maiden name of participant.

Provider Address — Enter Provider Agency address, (Street or Box number, City, State and Zip code)

Participant Address — Enter street number and name or rural route and box number.

Provider City, State, Zip Code — Enter as usual.

Participant City, State, Zip Code — Enter as usual.

MO HealthNet Provider Identifier — 10 digit provider identifier used for billing identification purposes.

Month Prenatal Care Began — Check appropriate box.

Telephone — Enter telephone number of participant (include area code).

Marital Status Code — Check the appropriate box.

Provider Taxonomy Code — 10 digit Provider Taxonomy Code used for billing identification purposes.

County— Enter County of residence.

Race Code — check the appropriate race box even if client is Hispanic (Hispanic is not a race).

Hispanic Origin — Check the appropriate box.

LMP — Enter date of last normal menstrual period (Use MM/DD/YY format).

Gravida — Enter the number of times participant has been pregnant including this pregnancy.

Para — Enter the number of previous deliveries 20 weeks gestation or beyond (includes stillborns).

Aborta — Enter the number of spontaneous and/or induced abortions experienced by participant.

Risk Factors — Enter an "X" in all of the boxes that apply to participant. An "X" in any one of the first 34 boxes qualifies participant for case management services.

Intended/Unintended Pregnancy — Check the appropriate box.

Specify Gestational Age — Enter the number of weeks pregnant at the time of the Risk Appraisal.

Approximate Due Date — Enter the approximate due date (Use MM/DD/YY format).

Physician's Performing Provider Identifier — Enter the MO HealthNet performing provider number of the physician or nurse practitioner affiliated with the clinic/agency.

Provider signatures — Sign and date. May be signed by an RN or physician.

Preferred Case Management Provider — Enter the name of the case management provider agency chosen by participant.