HOME VISIT REFERRAL FORM FOR MEDICAID BENEFICIARIES
Steps Ahead Maternity Care Program

To Be Completed By Referral Source

To: ______________________________ Health Dept.	Fax #:	Date:
Referral Source:	Contact Person:	Phone:

Patient Information

Patient Name:	Date of Birth:	Age:	Race: ☐ White ☐ Black ☐ Asian ☐ Hispanic ☐ Other ____________________
Medicaid Number:		Phone Number (include area code):	
Street Address:		City:	State:
Zip Code:	Alternative Phone Number:	DHCP:	

Clinical Information

EDD or Delivery Date	Maternal Para:	Infant Birth Weight & Sex:
Discharge Date:	Complications/Problems, if indicated: ______________________________	

Referral Criteria

(Please check appropriate box.)

☐ H001 – Under 16 years of age	☐ H007 – Infant Born <2500 grams
☐ H002 – HIV mother	☐ H008 – Multiple birth
☐ H003 – Drug and alcohol abuse	☐ H009 – Mulitparity < 20 years of age
☐ H004 – Mental illness/MR infant care	☐ H010 – Other: ___________________________
☐ H005 – Suspected abuse/neglect	☐ H011 – None Needed
☐ H006 – No prenatal care	☐ H012 – Attempted

Outcome: ☐ Home visit complete ☐ Patient refused home visit ☐ Attempted (Document Below)

To be Completed by Home Care Staff

Date	Contact Notes/Documentation of Attempted Visit

Fax referrals to the Home Visit Provider in the Beneficiary's County of Residence.

For information on Home Visit Providers, call Steps Ahead at 1-877-997-8377.

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