reach DANE reach GREEN

Family Advocate: ___________________
Date: ___________________

# Early Head Start: Pregnancy Enrollment

**Applicant's Name:** ______________________ ________________________ ____ **DOB:** ____ / ____ / ____
(Last) (First) (MI) Mo Day Year

*Current Address:* ______________________________________________ *Current Phone:* (      ) _______-________
______________________________________________

**Projected delivery date of child/children:** ____ / ____ / ____ **Date of Enrollment:** ____ / ____ / ____
Mo Day Year Mo Day Year

**Do you have Medical Coverage / Health Insurance?** □Yes □No

*If yes,*

| | |
|---|---|
| **MA:** □ Yes □ No | **Private Insurance:** □ Yes □ No |
| **Badger Care:** □ Yes □ No | Company: ________________________________ |
| **Healthy Start:** □ Yes □ No | Group: ___________ Individual: ___________ |
| **Other (Specify):**__________________________ | Policyholder: ____________________________ |
| **HMO:** □Dean □GHC □Unity | Policy #: _______________________________ |
| **If not, have you applied?** □ Yes □ No | |
| **Have you been turned down?** □ Yes □ No | |

**Name of primary health care provider:** □ **No Regular Provider**

____________________________________________
Doctor/Clinic Name

____________________________________________ ______________________________
Address Phone

**Name of primary prenatal provider:** □ **No Regular Provider**

____________________________________________
Doctor/Clinic Name

____________________________________________ ______________________________
Address Phone

**Have you had a dental exam and/or treatment within the last 12 months?** □Yes □No

If yes, Date of Exam: ___ / ___ / ___
Mo Day Yr

**Are you receiving medical care for ongoing medical conditions? Yes No**

**If yes, which conditions?** ________________________________________

**Are you receiving or have you received within the past 12 months, mental health services? Yes No**

**If yes, by which provider**______________________ **and at which clinic**________________________.

**Which medications are you currently taking or have taken within the past 12 months?** ______________