1115 Medicaid Waiver/Consent to be Enrolled in Case Management Services
San Antonio Metro Health STD/HIV Clinic

Case Management Enrollment Form		
PATIENTS NAME:		**Date of Birth:**
INSURANCE(IF ANY):		**LANGUAGE PREFERENCE:**
ADDRESS:		**CITY,STATE,ZIP:**
HOME PHONE NUMBER:	**CELL:**	**WORK:**
MONTHLY INCOME:		
Name Father of Child:	**Date of Birth:**	**Phone Number:**
Address:	**Age of Father:**	**Place of Employment:**
Who's your OB doctor?	**Where are you delivering the baby?**	
How many times have you been pregnant?	**When was your last period?** ____/_____/_____	**When is your due date?** ____/_____/_____
Who is your baby's pediatrician?		

PLEASE HELP ME:

- ☐ **FIND A PRENATAL DOCTOR**
- ☐ **SIGN UP FOR MEDICAID**
- ☐ **FIND A PLACE TO LIVE**
- ☐ **GET A RIDE TO MY APPOINTMENTS**
- ☐ **FIND PARENTING CLASS**
- ☐ **Sign up for WIC**
- ☐ **Other Please help me with**_____

Yes, sign me up. I acknowledge that I am being enrolled to the San Antonio Metropolitan Health STD/HIV Clinic Case Management for follow-up services due to my high-risk status as a pregnant client. I understand I have to come for all follow-up appointments to be eligible for free baby items. I also give consent for my case manager to follow-up with my Ob provider to request information regarding my pregnancy.

_____ _____ _____

Name **Signature** **Date**

No don't sign me up. I understand I am a high risk pregnant client and I do not want to be enrolled in case management services for follow up with San Antonio Metropolitan Health STD/HIV Clinic.

_____ _____ _____

Name **Signature** **Date**