# APPLICATION FOR STATE MATERNITY FUNDS
# (VOUCHER, SOCIAL HISTORY & SERVICE PLAN)
# PROBLEM PREGNANCY SERVICES

Today's Date:

## 1. AGENCY INFORMATION

| A. Agency | B. Caseworker |
|---|---|
| C. Address | D. Phone Number<br>Extension<br><br>E. E-Mail |

## 2. APPLICANT INFORMATION

| A. Applicant's Last Name | B. First | C. Middle Initial | D. US Citizen<br>Yes | E. Citizenship Verification Method |
|---|---|---|---|---|
| F. Birth Date | G. Race | H. Ethnicity | I. # of Previous Pregnancies | J. Outcomes of Previous Pregnancies<br>Live Birth Abortion<br>Other |
| K. Marital Status | L. Highest Grade Completed | M. Current Living Arrangement | | |

| N. Address | O. Expected Delivery Date |
|---|---|
| | P. Anticipated Admission Date |

| Q. People Living in Household (Other than Applicant)<br>Name Age Relationship to Applicant | R. Applicant's Present Employer |
|---|---|
| | S. Applicant's Employer's Address |

| T. Sources of Income | |
|---|---|
| Source | Monthly Gross Amount<br>$ |

| U. Monthly Resources Available for Placement Costs | | | | | |
|---|---|---|---|---|---|
| Applicant<br>$ | Private Insurance<br>$ | Parents/Relatives<br>$ | Expectant Father<br>$ | Others<br>$ | Referring Agency<br>$ |

| V. Complete This Section if Applicant is Under the Age of 18 | | |
|---|---|---|
| Parent's Last Name | First | Middle Initial |
| Present Employer | Employer Address | |

| W. For Office Use Only | | | |
|---|---|---|---|
| Family Size | Income Limit for This Size Family<br>$ | TANF Eligible?<br>☐ | NCDSS Number |

## 3. PROBLEM ASSESSMENT AND SERVICE PLAN

A. Is this a high-risk pregnancy? If so, explain.

B. What is the applicant's current plan for herself and her child after delivery?

C. Describe her family/friends/support system.

D. What efforts have been, or are being made, to help her receive needed services and support locally so that a residential placement might be avoided?

E. Why is this residential placement being considered?

F. Has she received SMF previously? If so, describe the placement including the residential setting, the year of entry, and the outcome for her and her child.

G. Service Plan for Applicant and Child

| Service | Currently Provided (List Agency) | Planned For (List Agency) | Not Needed | Refused |
|---|---|---|---|---|
| Education | | | | |
| Emotional Support/Counseling | | | | |
| Employment and Training | | | | |
| Family Planning | | | | |
| Food Stamps | | | | |
| Housing Following Delivery | | | | |
| Income Assistance – TANF, IV-D, etc. | | | | |
| Parenting Education | | | | |
| WIC or other Nutritional Plan | | | | |
| Other | | | | |

H. How will referring agency support this Service Plan?

## 4. RECOMMENDED RESIDENTIAL CARE PLAN

A. Proposed Living Arrangement

☐ Boarding Arrangement
☐ Home of Non-Legally Responsible Relative
☐ Licensed Family Foster Home
☐ Maternity Home: Name

B. Explain how this placement is the least restrictive as well as the most cost efficient placement possible for this applicant.

C. Current Medical Care Provider

D. Alternative Living Arrangement (Complete this section if residential arrangement is other than a maternity home)

D.1. Is Form DSS 6189 (Rev. 11/03) attached?

| D.2. Date of On-Site Visit | D.3. Name of Individual Maintaining Living Arrangement | D.4. Address |
|---|---|---|
| | | |

D.5. Describe Physical Environment (Sleeping Arrangement, Privacy, Space for Personal Belongings, Bathroom Facilities, Heating)

D.6. Describe Food and Nutrition Plan

D.7. Describe Laundry Facility

| |
|---|
| D.8. Describe Transportation Resources (Emergency Needs, Medical Needs, and Accessibility to Other Resources) |
| Describe Meeting Emotional Support<br>D.9. |
| Describe Addressing Special Needs<br>D.10 |

## 5. CERTIFICATION

I certify the information I have given is accurate and complete to the best of my knowledge. I understand that this information may be verified.

| | |
|---|---|
| A. Applicant Signature | B. Date |
| C. Parent Signature ( If Applicant is a Minor) | D. Date |
| E. Caseworker Signature | F. Date |

Send original application to:

State Maternity Fund Coordinator
NC Division of Social Services
Child Welfare Services
PO Box 127
Icard NC 28666

If additional information is needed, call (828) 397-3901