Maternity Application Assister Encounter Form

Entity Name: _____

Application Assister Name: _____

Date: _____

Recipient Information

Last name	First name
Address	
Telephone number	
Alternate telephone number	
County	

Eligibility

Medicaid eligibility: Applied _____	Pending _____	Approved_____
Is the Recipient in the 1st Trimester?	Yes_____	No_____
Application Assister Services Provided?	Yes_____	No_____
Explain Services Provided:		