

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
MATERNAL AND INFANT CARE COORDINATION

SERVICE PLAN

Client's Name _____ Client's Medicaid # _____

Date Primary Care Provider Notified of Client's Enrollment in
BabyCare _____

RISK NO.	DATE	IDENTIFIED NEEDS/PROBLEMS	PLAN	FOLLOW UP

I agree with this service plan and will work with my care coordinator to get the services I need.

Client's Signature: _____

Date: _____

Care Coordinator's Signature: _____

Date: _____

