

Public Health

Delta & Menominee Counties Maternal Infant Health Program (MIHP)

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Referral for Service

Are you presently enrolled	in a Maternal Infant Health Program? Yes
Adult Client Name:	or Infant Client Name:
Client Birthdate	Due Date:
Suspect usage of drugs by o	ent or someone in the home? Yes No Unknown
Parent/Guardian of Infant	
Address	City/State/Zip
Directions to above address:	
Home Phone	Cell Phone
May we call you at these nu May we send you mail at the	above address? Yes No above address? Yes No Yes No Yes No. If yes, your cell phone carrier is:
Physician	
Medicaid #	PendingApplication sent
Has Private Insurance? □Yes □N	Name of Insurance#_
Subscriber Name	DOBAddress
Has Private Insurance, but has no in	ormation available today.
Original Date of MIHP Refe	ral
	Agency
Agency Phone	Agency address
MIHP Letter Sent	
CONTACT LOG	
Phone Date:	
Phone Date:	
Phone Date:	
Letter Date:	