ARIZONA DEPARTMENT OF HEALTH SERVICES
High-Risk Perinatal Program/Newborn Intensive Care Program
Request for Participation Page 1 of 2

Place required label here

PLEASE PRINT ALL INFORMATION

INFANT'S INFORMATION

1. Infant's Last Name	2. Suffix	3. First Name	4. MI	5. DOB	6. Gender M F U

7. Alias: Last Name	8. Alias: First Name	9. Race ☐American Indian / Alaskan Native, ☐Asian, ☐Black / African American, ☐White, ☐Native Hawaiian / Pacific Islander, ☐ Bi-Racial / Multi-Racial ☐Unknown	10. Ethnicity ☐Hispanic/Latino ☐Not Hispanic/Latino

11. Street Address (No. P.O. Box)	12. City	13. State	14. Zip	15. County

16. Tribe (select one)
☐Apache ☐Pueblo ☐Pima
☐Chemehuevi ☐Quecham ☐Other (specify) _____
☐Cherokee ☐Seminole
☐Choctaw ☐Seneca
☐Cocopah ☐Shoshone ☐Unknown
☐Creek ☐Sioux
☐Havasupai ☐Tohono O Odham
☐Hopi ☐Ute
☐Hualapai ☐Washoe ☐Not Applicable
☐Maricopa ☐Yavapai
☐Mohave ☐Yuma
☐Navajo ☐Zuni
☐Paiute (Kaibab)
☐Pasqua Yaqui

17. Reservation (select one)
☐Ak Chin
☐Camp Verde (Yavapai - Apache)
☐Cocopah
☐Colorado River(Mohave-Chemehuevi)
☐Fort Apache
☐Fort McDowell (Yavapai-Apache)
☐Fort Mohave
☐Fort Yuma (Quechan)
☐Gila Bend
☐Gila River (Pima-Maricopa)
☐Havasupai
☐Hopi
☐Hualapai
☐Kaibab-Paiute (Paiute)
☐Maricopa Ak Chin
☐Navajo Nation
☐Pasqua-Yaqui
☐Payson-Yavapai
☐Salt River (Pima-Maricopa)
☐San Carlos (Apache)
☐San Juan Southern Paiute
☐San Xavier
☐Tohono O Odham (Formerly Papago)
☐Yavapai-Prescott (Yavapai)
☐White Mountain Apache
☐Zuni Pueblo
☐Other (specify): _____
☐Unknown
☐Not Applicable

18. Birth Hospital	19. Current Hospital (if not birth hospital)	20. Infant's Insurance

FAMILY INFORMATION

21. Mother's Last Name	22. Mother's First Name	23. MI	24. DOB
25. Alias: Last Name / Maiden Name	26. Alias: First Name	27. Phone # ( )	

28. Marital Status: ☐ Divorced, ☐ Living Together, ☐ Married, ☐ Never Married, ☐ Separated, ☐ Widowed, ☐ Unknown

29. Race: ☐ American Indian / Alaskan Native, ☐ Asian, ☐ Black / African American, ☐ White, ☐ Native Hawaiian / Pacific Islander, ☐ Bi-Racial / Multi-Racial ☐ Unknown

30. Ethnicity ☐ Hispanic/Latino ☐Not Hispanic/Latino

31. Mother's Highest Grade Completed: ☐ ≤8th, ☐ 9-11th, ☐ High School Grad/GED, College: ☐ < 2 yr, ☐ 2 yr, ☐ 4 yr, ☐ 6 yr+

32. Primary Language Spoken at Home:

33. Second Phone # ☐ None ( )

34. Father's Last Name	35. Suffix	36. Father's First Name	37. MI	38. DOB

PRIMARY CAREGIVER (if not Mother and/or Father)

39. Caregiver's Last Name	40. First Name	41. Relationship	42. Phone # ( )

43. Street Address	44. City	45. State	46. Zip

CONTACT INFORMATION (someone who will always know how to reach family)

47. Contact: Last Name ☐ None	48. First Name	49. Relationship	50. Phone # ( )

Distribution by Enrolling Contractor: Original to ADHS Yellow to CHN <u>Pink to Family</u> Copy for Development Follow-up if High Risk
FOR ALL TRANSPORTS AFTER INITIAL HOSPITAL ENROLLMENT: Sending hospital -Copy p1 & p2 of this form to accompany baby to receiving Level II, II EQ or III hospital. Transport carriers do not receive copies of this form.
6-HRPP-002/NICP RFP Page 1 of 2 (06/06)