



Baby & Me Enrollment Request

Aloha and thank you for your interest in our free Baby & Me Program!

Pregnancy can be such a wonderful and happy time for a woman and her family. At HMAA, we want to ensure you and your unborn child have the very best opportunity for a healthy pregnancy and delivery. Baby & Me is dedicated to helping you take measures to ensure a healthy delivery and baby by providing education, intervention and guidance, along with great incentives.

Please complete the following questionnaire as soon as possible, and no later than **week 20** of your pregnancy. **After week 20, you will not be able to enroll.**

Once your enrollment is confirmed, we will contact you regarding these incentives and next steps:

- Digital ***My 9 Months*** guide from March of Dimes containing information about pregnancy stages, nutrition, baby care, and more
- Free six-month rental of a physician-grade **fetal Doppler** to hear your baby's heartbeat at home or on-the-go
- **Breast pump** through an in-network provider. Purchases from out-of-network providers are eligible for reimbursement of up to \$357.
- Reimbursement of **prenatal class fees**, up to \$150
- **\$250 Target GiftCard**

About 12.5% of pregnancies can result in complications. Through early identification of risk factors, certain complications can be prevented. We are pleased to help you through your pregnancy.

If you have any questions, please contact our Wellness Department at (808) 791-7635, toll-free at (888) 941-4622 x635, or BabyandMe@hmaa.com.

Mahalo,

HMAA Wellness Team

Baby & Me Pregnancy Questionnaire

Please send this questionnaire to HMAA within the **first 20 weeks** of your pregnancy. **Note: Submitting this form does not constitute program enrollment.**

Email: BabyandMe@hmaa.com Fax: (808) 535-8371

Mail: HMAA Wellness
220 South King Street, Suite 1200
Honolulu, Hawaii 96813



Participation in HMAA's Baby & Me, a free maternity and baby care incentive program, is voluntary and does not affect your health plan benefits. The information requested on this form will be used to determine your eligibility for this program and is necessary to help our Wellness and Clinical team identify your pregnancy risk level to provide you with appropriate maternity and baby care service options. All information is confidential and will be treated as protected health information. Incentives are contingent upon active engagement with HMAA.

Applicant Information

Name of Applicant		Member ID	Date of Birth (mm/dd/yy)
Mailing Address			
City	State	Zip	Email
Phone	Preferred Time of Day to Contact <input type="checkbox"/> No Preference <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening		

Health and Pregnancy Information

Risk Factors 1. History of Smoking <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Pregnant with Multiples <input type="checkbox"/> Yes <input type="checkbox"/> No - If Yes, # of babies? _____ 3. In Vitro Fertilization Pregnancy <input type="checkbox"/> Yes <input type="checkbox"/> No 4. Artificial Insemination Pregnancy <input type="checkbox"/> Yes <input type="checkbox"/> No 5. Abnormalities of Uterus/Placenta <input type="checkbox"/> Yes <input type="checkbox"/> No 6. Bleeding Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No 7. Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No 8. Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No 9. High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No 10. Incompetent Cervix <input type="checkbox"/> Yes <input type="checkbox"/> No 11. Pregnancy in Last 18 Months <input type="checkbox"/> Yes <input type="checkbox"/> No	Height (ft. in.)	Body Mass Index (optional)
	Current Weight (lbs)	Pre-Pregnancy Weight (lbs)
	Date Last Menstrual Period Began (mm/dd/yy)	First Prenatal Appointment Date (mm/dd/yy)
	Expected Delivery Date (mm/dd/yy)	Anticipated Delivery Type <input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section
	# of Previous Pregnancies	# of Previous Miscarriages
	# of Children Given Birth To	# of Premature Babies
	Name of Primary Care Physician	Name of OB/GYN or Midwife

Electronic Consent

Initials of Applicant	By initialing this box, you acknowledge and agree that the individual completing this form is the member requesting enrollment in Baby & Me, and HMAA can accept your personal information on this form electronically in a secure manner. Your electronic signature will consist of your typed name and contact information shown above (e.g., email address, phone number, and/or mailing address) that are unique to you and will be used as the equivalent of a manual signature. HMAA may contact you to verify your consent.
Date Initialed (mm/dd/yy)	

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