Black Infant Health Enrollment Form

Maternal, Child and Adolescent Health Division
Black Infant Health Program

BIH Eligibility Requirements
1) African-American Women, who Identify as AA
2) At least 18 years of age at enrollment
3) No later than 30 weeks pregnant at enrollment
4) Must be San Francisco Resident
5) Must be delivering baby in SF County

ATTN: BIH Enrollment Team
SF Black Infant Health Program
For more information, please call:

Office: (628) 217-5399
email:BIH@sfdph.org

***Recruitment Date (*Program Start Date*):**____/_____/ ____

PARTICIPANT INFORMATION (Add new participant)

Case Number:_____

***First Name**: _____ **Middle Name:**_____ ***Last Name:**_____

Maiden Name: _____ ***Participant's DOB**: _____/_____/_____

Home Address (Address 1):_____ **Apt/Ste/Bldg # (Address 2):**_____

City:_____ **State:**_____ ***ZIP Code**: _____

Mailing Address: _____

City:_____ **State:**_____ **ZIP Code:**_____

Home Phone: ( ) _____-_____ **Work Phone: ( )**_____-_____

Email: _____

What is the best way to contact you? _____

REFERRAL INFORMATION (Recruitment Touch Point)

Date Referral Made (*Provider*): ____ / ____ / ____ ***BIH Staff Name:** _____

*Due Date: _____/_____/_____

*First-time mom? ☐ **Yes** ☐ **No** ☐ **Unknown**

*Referral Source Type **(Check primary source):**		
	☐ **Social Service Provider** ☐ **Medical Provider** ☐ **County Health Department**	☐ **Word of Mouth** ☐ **Other BIH Participant** ☐ **Returning BIH Participant (previous pregnancy)**
	☐ **BIH Staff Outreach- Health fair** ☐ **BIH Staff Outreach- Street**	☐ **Media** ☐ **Other:** _____

For *provider-based referrals*, was the participant information received initially via automated list/report? ☐ **Yes** ☐ **No**

Name of Referral Organization (if provider-based referral): _____

Contact Person: _____ Phone Number: ( ) _____-_____

Name of Referring BIH Staff (if health fair or street outreach): _____

Dismiss Participant from Recruitment Program (to be completed by BIH Staff)
***Program End Date:**____/_____/____
***Dismissal Reason:**
(CHECK ONE)
☐ Enrolled in BIH (consent signed)

☐ **Staff unable to contact**
☐ **Not eligible**
☐ **No time available to**
☐ **participate not interested**
☐ **Needs could not be met by BIH**
☐ **Cannot participate due to transportation, childcare, or other barriers**
☐ **Other:** _____