



Gift of Life
Maternity Care Program

GIFT OF LIFE FOUNDATION MATERNITY CARE PROGRAM Enrollment/Agreement to Receive Care

Office Use Only:
Aid Type: _____

_____		_____		_____		Marital Status: _____		Race: _____	
<i>Mom's Last Name</i>		<i>First Name</i>		<i>MI</i>		<i>(S,M,D,W)</i>		<i>(C,B,H,AN,A/PI)</i>	
Address _____			City _____		Zip _____				
PO Box (if applicable) _____			City _____		Zip _____				
County _____		Tel #1 _____		Tel#2 _____		Email _____			
Date of Birth ____/____/____		App. Asst. Needed _____		Mom's Medicaid # _____					
Enrollment Site _____			EDC ____/____/____		Social Security # _____				
			<i>(Date)</i>						

I have reviewed the Delivering Health Care Professional List dated _____.

I have selected _____ as my health care provider.
(print provider name)

I have chosen _____ as my delivering hospital.
(name of hospital)

I have chosen _____ as my site of prenatal care.
(name of site)

- I have been told that I can change my mind about this choice within 90 days for any reason.
- I have been told that I have the right to change my mind about who gives me care at any time there is a good reason.
- I agree to go to doctors, clinics, hospitals, and other places for care that are set up for me while I am pregnant and after my baby is born.
- I agree to follow the plan of care that has been set up for me by my doctor, midwife, or other person who provides my care.
- I have been told that a real emergency is when I have a health problem that can cause death or lasting injury to my unborn baby or to me.
- I have been told what my rights and duties are under the Medicaid Maternity Care Program.
- I have been told what I need to do if I have a problem that I cannot solve on my own.
- I have reported other insurance that I have.
- I have had the chance to ask questions about anything that I did not understand and to have my questions answered in a manner in which I understand.

Permission and Release of Information: I give my permission to the Gift of Life Maternity Care Program, and any and all subcontractors and other community resources with whom the Gift of Life cooperates, to perform tests and procedures necessary for my maternity care unless I have a religious or moral belief that prevents me from giving my permission; to release any information, for treatment purposes or to expedite my care or the care of my baby; and to release any information acquired in the course of my enrollment, treatment, or examination to the Alabama Medicaid Agency, my insurance company, or other entities as are necessary for reimbursement purposes and health care operations. I also give permission to release any medical records about my baby. I agree that information about me or my health may be given to state and federal government agencies.

- I have reviewed, understand, and have been given a copy of:
- Enrollment/Agreement to Receive Care form
 - Release of Information (above)
 - Recipient Rights and Duties/Maternity Care Fact Sheet
 - HIPAA Notice of Privacy Practices
 - Care Coordinator Card with her name and phone number

Signed: _____
(Patient Signature)

(Date Signed)

(Person Enrolling Patient)

(Date Signed)

White – GOL OFFICE

Yellow – DHCP/CHART

Pink - CARE COORDINATOR/CHART

Gold – PATIENT