



GIFT OF LIFE FOUNDATION MATERNITY CARE PROGRAM Notification of DHCP Change/Program Dropout

Name _____ DOB ____/____/____
Medicaid Number _____ EDC ____/____/____
Address _____ City _____
State _____ Zip Code _____ Phone Number(s) _____

SECTION I – NOTIFICATION OF DELIVERING HEALTHCARE PROFESSIONAL CHANGE

I want to change my health care professional to:

(First Name) _____ (Last Name) _____

My Care Coordinator will be: _____

I wish to be delivered at (Name of Hospital): _____

I have been receiving care from:

(First Name) _____ (Last Name) _____

Reason for Change: Grievance Approved
 Patient moved within the district and travel to DHCP is more than 50 miles.
 Other- List: _____

SECTION II – NOTIFICATION OF PROGRAM DROP OUT

- _____ 1. Patient moved out of district _____
Location Date of Move
- _____ 2. Pregnancy ended prior to 21 weeks with no vital signs or baby weighed less than 500 grams with no vital signs.
_____ Weeks Gestation or Weight When Pregnancy Ended Date Pregnancy Ended
- _____ 3. Patient was denied by Medicaid.
- _____ 4. Other- Explain: _____

Patient's Signature _____ Date Signed _____

Care Coordinator's Signature _____ Date Signed _____