



**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 \_\_\_\_\_

**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 \_\_\_\_\_

White – GOL OFFICE

Yellow – DHCP/CHART

Pink - CARE COORDINATOR/CHART

Gold – PATIENT