



# 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 \_\_\_\_\_

White – GOL OFFICE      Yellow – DHCP/CHART      Pink - CARE COORDINATOR/CHART      Gold – PATIENT