



High Risk Pregnancy Medical Report

Return to:

DCF – Economic Services Division
Application and Document Processing Center
280 State Drive
Waterbury, VT 05671-1500

Date _____

Dear Health Care Provider:

Adults receiving financial assistance from the Economic Services Division are required to work, look for work, or prepare for work by participating in job training or educational activities. We expect participants to work to the extent possible.

The person named below has professed an inability to work because she has a high risk pregnancy. She has identified you as the health care provider most knowledgeable about her pregnancy. Please complete the back of this form to help us determine if this person is unable to work due to a high risk pregnancy.

Thank you for completing this form and returning it to the above address within 10 days.

Patient name _____

Social Security no. xxx-xx-_____
(Last four digits only)

Address _____

Telephone number _____

Authorization to Release Information

I hereby authorize the release of the medical and clinical information requested in this report to the Department for Children and Families, Economic Services Division.

Signature of patient or authorized representative

Relationship to patient

Date

High Risk Pregnancy Determination

Patient name _____

Social Security no. xxx-xx-_____
(Last four digits only)

Estimated delivery date ____/____/____

Please check one of the following:

Patient is pregnant and able to work.

Patient is unable to work due to a high risk pregnancy

Provider name _____ Provider number _____

Address _____ Telephone number _____

Provider signature _____

Date _____