210HRP

Department for Children and Families
Economic Services Division

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

Revised 10/2015

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 _____