NORTH CAROLINA CMHRP/CMARC PROGRAM
REQUEST FOR TERMINATION AND TRANSFER OF SERVICES FORM

Local Health Departments (LHD) must complete and submit this form to request termination or transition of Care Management for High-Risk Pregnancies (CMHRP) and/ or Care Management for At-Risk Children (CMARC) services. Completed forms should be submitted to DPH CMHRP Program Manager, DPH Division Director, DCFW CMARC Program Manager, and DCFW Division Director.

All requests must be submitted at least **180 days prior** to the requested effective date of service termination.

Through this request, you are hereby attesting that your Health Department will no longer be eligible to receive CMHRP and/or CMARC payments upon the effective date of service transition.

Local Health Department Details	
Requestor Name:	Requestor Title:
Email:	Phone Number:
LHD Name:	Counties Covered:
Local Health Department Address:	Zip Code:
City:	State:
Request Details	
Request Type: ☐ Full Transition of Services for All populations (Select all applicable) ☐ Standard Plan Enrollees ☐ Tailored Plan Enrollees ☐ NC Medicaid Direct Enrollees ☐ EBCI Tribal Option Enrollees ☐ Other/Uninsured Patients ☐ Partial Transition of Services (Select all applicable) ☐ Standard Plan Enrollees ☐ Tailored Plan Enrollees ☐ NC Medicaid Direct Enrollees ☐ EBCI Tribal Option Enrollees ☐ Other/Uninsured Patients	☐ Initial Request ☐ Follow-up Request Program: ☐ CMHRP ☐ CMARC ☐ Both Request Reason(s): ☐ Staffing Issues ☐ Financial Hardship ☐ Other, please explain
Request Date (Today's Date):	Requested Effective Date:
Transition Details	
Estimated Current Caseload Count: CMHRP: ____________ CMARC: ____________	Has A Coverage Plan Been Identified for Service Delivery Post Termination Date? ☐ Yes ☐ No
Service Coverage Transition Description or coverage updates:	
Health Director Signature:	
Date Signed:	

Provide additional details here, if necessary: