



**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: <input type="checkbox"/> Full Transition of Services for All Populations (Select all applicable) <input type="checkbox"/> Standard Plan Enrollees <input type="checkbox"/> Tailored Plan Enrollees <input type="checkbox"/> NC Medicaid Direct Enrollees <input type="checkbox"/> EBCI Tribal Option Enrollees <input type="checkbox"/> Other/Uninsured Patients <input type="checkbox"/> Partial Transition of Services (Select all applicable) <input type="checkbox"/> Standard Plan Enrollees <input type="checkbox"/> Tailored Plan Enrollees <input type="checkbox"/> NC Medicaid Direct Enrollees <input type="checkbox"/> EBCI Tribal Option Enrollees <input type="checkbox"/> Other/Uninsured Patients	Program: <input type="checkbox"/> CMHRP <input type="checkbox"/> CMARC <input type="checkbox"/> Both Request Reason(s): <input type="checkbox"/> Staffing Issues <input type="checkbox"/> Financial Hardship <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No
Service Coverage Transition Description:	
Health Director Signature:	
Date Signed:	