Iowa Department of Human Services

MEDICAID REFERRAL

County No.________________________

Referring Worker No.________________________

Date of Referral________________________

Client (Child)________________________________

S.S. No.________________________________

Custodial/Relative________________________________

Address________________________________

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In order to ensure that services continue to be provided to children in Iowa, we are referring you and your family to apply for the Medicaid program.

Your cooperation will help us to maximize the use of state dollars and federal money for the provision of services.

If you are found eligible, Medicaid will cover not only the cost of social services, but also medical services (i.e., doctor, hospital, pharmacy, dental, etc.) for your family.

Please complete the enclosed application and return it to the county Department of Human Services office within ten days. An appointment will then be scheduled for an interview. You will need to provide verification of your family's income and resources and you will need to provide social security numbers for all family members.

The address and phone number of your county DHS office is:

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( )
( )
( )

County Stamp

White: Client Yellow: County IM Unit Pink: Case record

470-3061 (9/93)