Medicaid Prior to Release

Attach this form to the *Application for Health Coverage and Help Paying Costs.*

Reminder: This application process should not be used for offenders going to any work release status.

First name, middle name, last name	
Date of birth (mm/dd/yyyy)	Sex: ☐ Male ☐ Female
Social Security Number (SSN)	Medicaid ID number, if you know what it is:
Address where you will reside after release:	
Name of facility and address where you now reside:	
Date of admission:	Scheduled release date:
DOC staff assistor name (print)	
DOC staff phone number	DOC staff fax number
DOC staff assistor email address	

Mail to: Imaging Center 4
PO Box 2027
Cedar Rapids, IA 52406

DHS worker's phone number:
319-208-5513