Iowa Department of Human Services

Inmate Inpatient Care

Attach this form to the *Application for Health Coverage and Help Paying* Costs. Use this form only with an application for an inmate who is provided inpatient medical services. This must be attached for correct eligibility processing for Medicaid.

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:
Name of the DOC prison, county, jail or other public non-medical institution and address where you now live:	
Dates of inpatient care: through	
Name of hospital:	
Hospital staff assistor name (print)	
Hospital staff phone number	Hospital staff fax number
Hospital staff assistor email address	
Mail to: Imaging Center 4 PO Box 2027 Cedar Rapids, IA 52406	Questions? DHS worker's phone number: 319-208-5513