OPT-OUT MEDICAID FORM

Date: _____

Offender Name: _____ DOC#: _____

By signing this document, I am declining to participate in Medicaid Enrollment. I understand that even though I am declining Medicaid Enrollment now, that I may still request these services once released from prison. Though I am declining to participate, I have been provided the opportunity to discuss my questions or concerns about Medicaid Enrollment.

_____ _____

Offender Signature Date

_____

Employee's Name (Print Name)

_____

Employee's Signature