Minnesota Department of Corrections
APPLICATION FOR COVID-19 CONDITIONAL MEDICAL RELEASE

Inmates may be eligible for conditional medical release if they suffer from a grave medical condition, their release poses no threat to the public, and their health costs are likely to be borne by the inmate, medical assistance, Medicare, or veteran's benefits. Those who wish to be considered for conditional medical release based on the current COVID-19 situation should complete this application and submit it to the CMR Process Contact at CMRrequest@state.mn.us or the following mailing address:

Minnesota Department of Corrections
ATTN: Conditional Medical Release Process Contact
1450 Energy Park Dr., Suite 200
St. Paul, MN 55108

Do not attach additional pages or documents to this application, as they will not be considered.
Inmates who have previously applied for and been denied conditional medical release may not reapply absent a material change in their underlying medical condition or other circumstances.

NAME: _____ OID: _____

AGE: _____ OFFENSE(S): _____

SENTENCE: _____ SUPERVISED RELEASE DATE: _____

CURRENT FACILITY: _____ CUSTODY CLASSIFICATION: _____

Describe your serious medical condition:

Identify one or more specific residences or placements where you know you can live if released, including addresses and, if a private residence, the name and age of each person living there:

Do you know if you are eligible for veteran's benefits or other state or federal healthcare coverage?

Explain why you believe you pose no threat to the public:

Briefly describe your release goals:

Identify and provide contact information for at least two people who will serve as your support network if released:

I understand that I have no right to conditional medical release and, even if I meet the eligibility requirements, my application may still be denied in the DOC's discretion. I understand that if I am placed on conditional medical release due to the current COVID-19 pandemic, my release may be rescinded without a hearing once the pandemic subsides or my medical condition otherwise improves to the extent that continuation on conditional medical release presents a more serious risk to the public. I also understand that my conditional medical release may be revoked if I violate any condition of my release.

I understand that any private data I provide in this application will be reviewed by DOC and non-DOC individuals to assess my eligibility for conditional medical release. I understand that failure to provide the requested information may affect the processing of my application and result in its denial. By signing this application, I acknowledge that I have reviewed it. [Note: the application process cannot begin until the inmate has reviewed and signed the application].

Inmate's Signature: _____ Date: _____

Name, email, and phone number of individual/entity providing assistance to applicant (if any):

☐ I authorize this individual/entity to be notified of the final determination on my application.