Iowa Department of Human Services

DESIGNATION OF PERSONAL REPRESENTATIVE

Name of Client	Date of Request	
Mailing Address – Street or P.O. Box	Social Security Number, Patient Number, or State ID	
City, State, and Zip Code	Phone Number	Birth Date
Check all of the programs that apply: ☐ Medicaid ☐ ***hawk-i*** ☐ Facility		

To be completed by client

I designate ______________________________ to act as my personal representative.
(Name of Person)

Relationship of personal representative to client:

☐ Son or daughter
☐ Spouse
☐ Friend
☐ Attorney
☐ Other (Please specify) ______________________________

Client's Signature	Date