

Iowa Department of Human Services

SERVICE REPORT

Client Name		Social Security No.	Case Number	
Address		Telephone Number ()	Birth Date	
SSI Recipient <input type="checkbox"/> Yes, Aged <input type="checkbox"/> Yes, Blind <input type="checkbox"/> Yes, Disabled <input type="checkbox"/> No				
Representative Name			Telephone Number ()	
Address		City	State	Zip Code

IN-HOME HEALTH-RELATED CARE

Line 1	<input type="checkbox"/> New Application			
	<input type="checkbox"/> Payment for services will be	\$ _____	Effective date	_____
	<input type="checkbox"/> Applicant eligible, client participation	\$ _____	Medical effective	_____
Line 2	<input type="checkbox"/> Change in service payment to	Amount \$ _____	Effective	_____
Line 3	<input type="checkbox"/> Change in client's income to	Amount \$ _____	Effective	_____
	<input type="checkbox"/> Client participation changed to	Amount \$ _____	Effective	_____
	Notice of Decision sent, copy attached			
Line 4	<input type="checkbox"/> Change in living arrangement effective	_____		
	a. <input type="checkbox"/> Hospital (cancel payments after 15 days)			
	b. <input type="checkbox"/> ICF <input type="checkbox"/> RCF <input type="checkbox"/> SNF (cancel payments)			
	c. <input type="checkbox"/> Services discontinued (cancel payments)			
	d. <input type="checkbox"/> Death (cancel case)			
	e. <input type="checkbox"/> Other (specify) _____			
Line 5	<input type="checkbox"/> Applicant Ineligible			
	<input type="checkbox"/> Notice of Decision sent cancelling:	<input type="checkbox"/> Payment	<input type="checkbox"/> Medical	
	Date of cancellation	_____		
Service Worker		Telephone Number ()		
Income Maintenance Worker		Telephone Number ()		

Double Click to **SEND** Form