



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: <input type="checkbox"/> Medicaid <input type="checkbox"/> <b>hawk-i</b> <input type="checkbox"/> 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