

Health and Human Services

User Change Request Form

Please complete and email original signed form to the email address at the bottom of this document.

Name of User: _____

Driver's License#: _____ Issuing state of DL#: _____

Change of Name:

Original Name (First, Middle, Last): _____

New Name (First, Middle, Last): _____

Agency Employment Change:

Original Employment Agency: _____

New Employment Agency: _____

Change of Email Address:

Original Email: _____

New Email: _____

Change of Rights:

WIC Coordinator CPA Support Staff Admin View Only

FOCUS Security Admin Support Staff BF PC

Rights CPA Scheduler only WIC Direct

(select only one): Non-CPA Professional LA Reports Only IMPA

Organization: _____ Org. Phone#: _____

Coordinator Signature: _____ Date: _____

For HHS Use Only:

Authorized Program Staff Signature: _____

Date Received: _____ Phone: _____

For Bureau Of Information Management Use Only

Date Completed: _____

email signed form to:
wichd@hhs.iowa.gov