Iowa Department of Human Services

DOCUMENTATION OF CLAIM DETERMINATION

Household Name	Case No.
Address	State ID No. (Same as one listed on form 470-0464)
County Office	Worker No.

Is this a correction of a claim? ☐ Yes ☐ No
(If yes, attach this and the corresponding copy of form 470-0464 to the original claim documents.)

Certification periods covered by the claim:

CERTIFICATION PERIOD(S)		DATE CERTIFICATION PERIOD ESTABLISHED	BASED ON APPLICATION DATED
FROM	THROUGH		

	ACTUAL ISSUANCE			CORRECT ISSUANCE			
Issuance Month	HH Size	Net Income	Monthly Allotment	HH Size	Net Income	Monthly Allotment	Amount of Overissuance
		$	$		$	$	$
		$	$		$	$	$
		$	$		$	$	$
		$	$		$	$	$
		$	$		$	$	$
		$	$		$	$	$
		$	$		$	$	$
		$	$		$	$	$
		$	$		$	$	$
		$	$		$	$	$
		$	$		$	$	$
		$	$		$	$	$
		TOTALS	$			$	$

Explanation of the cause of the overissuance (Must be completed)
(Who, What, Where, When, and Why)

Worker Signature	Date
Supervisor Signature	Date

Calculate!