Iowa Department of Human Services

Request for Special Update

Please complete all information to build SSNI file.

Date	Worker Name		County No.	Worker No.	Worker Telephone	
State ID #	Case No.	Case Name			Recipient Name	
Mailing Address				City	State	Zip Code
US	ID	Ethnic Code	Date of Death*	Person No.	Sex	Handicap Code	DOB

*(If stillborn, request not needed for baby, claims should be for mother only.)

IF A MEDICALLY NEEDY PERIOD WITH A SPENDDOWN IS NEEDED, PLEASE REVIEW 14-I BEFORE COMPLETING THIS FORM.

☐ 1. Update Eligibility

☐ 2. Add Medicare

☐ 3. Delete Medicare (Use only for Medicare code; otherwise use the SIQ procedure to submit TPL information.)

☐ 4. Add Newborn

Mother's State ID	Mother's Name

☐ 5. Add Enhanced Services Only

From	Through	County of Residence	County of Settlement	Aid Type	Fund Code	Medicare Code	Special Claims	MN Spend down	MN	POV	Foster Care Med
MM/YY	MM/YY	COR	COS	Aid	F	INS	SP	Y/N	PR	PP	MP

Quality Assurance Signature
Signature