

Certificate of Authority Interim Assistance Reimbursement (IAR)

Agency providing Interim Assistance Reimbursement	
Name of certifying official	Title

Servicing County Agency Identifying Information		
GR code	County agency name	
Mailing address		
City	State	Zip Code

I certify that the following staff of this agency are authorized to sign documents reporting the receipt and disbursement of interim assistance reimbursement received in accordance with the *Interim Assistance Agreement* between this agency and the state of Iowa.

Name	Job title	
E-mail address	Telephone number	Ext.

Name	Job title	
E-mail address	Telephone number	Ext.

Name	Job title	
E-mail address	Telephone number	Ext.

Servicing Agency Direct Deposit Information
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Please attach a statement from the financial institution verifying the information.

Direct deposit routing number	Direct deposit account number
Direct deposit account type (checking/savings)	

Signature of certifying official	Title	Date
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Distribution:

Send the original to:
 Social Security Administration
 IAR Coordinator
 601 E 12th St, Room 1073
 Kansas City, MO 64106

Send a copy to:
 Department of Human Services
 Iowa Medicaid Enterprise
 IAR Program Manager
 1305 E Walnut St
 Des Moines, IA 50319-0114

Keep a copy for your agency records.