Iowa Department of Human Services

REPORT FOR ENHANCED SERVICES

Section A. Completed by provider.

Recipient Name (Last, First, M.I.)	Birth Date	State I.D. Number	
Street	City	State	Zip Code
County of Legal Settlement (name and number)	Date Legal Responsibility Was Assumed		
Primary Diagnosis ☐ Mental Retardation **(M)**	☐ Chronic Mental Illness **(I)**	☐ Developmental Disability **(S)**	
Provider Name	Provider Number	Telephone Number	
Street	City	State	Zip Code
Service ☐ Case Management	☐ Day Treatment	☐ Partial Hospitalization	
Director or Designee Signature			

Section B. Completed by Department of Human Services.

Date Received	Date Entered	Signature

470-2464 (4/90) Copy 1: Local Department of Human Services Office Copy 2: Provider