Department of HUMAN SERVICES

Request for IoWANS Changes

Part 1: Member/Staff Information	
Member State ID	Member Name (Last, First)
Worker Name	Date Completed

Part 2: Eligibility Changes

Program request that needs changes:

Begin Date	End Date	Program

Correct Information:

Begin Date	End Date	Aid Type	Program	Co Res	Co LS

CP 1st Month	CP Ongoing	Provider # (Facility Only)	NF Provider #, if Hospice	Application Date

Second occurrence (if needed):

Program request that needs changes:

Begin Date	End Date	Program

Correct Information (second occurrence):

Begin Date	End Date	Aid Type	Program	Co Res	Co LS

CP 1st Month	CP Ongoing	Provider # (Facility Only)	NF Provider #, if Hospice	Application Date

Third occurrence (if needed):

Program request that needs changes:

Begin Date	End Date	Program

Correct Information (third occurrence):

Begin Date	End Date	Aid Type	Program	Co Res	Co LS

CP 1st Month	CP Ongoing	Provider # (Facility Only)	NF Provider #, if Hospice	Application Date

Comments:

Mail to: Outlook, DHS, IoWANS-Facilities

SUBMIT ONLINE