Iowa Department of Human Services

Designation of Personal Representative

Name of Client	Date of Request	
Mailing Address – Street or P.O. Box	Social Security Number, Patient Number, or State ID	
City, State, and Zip Code	Phone Number	Birth Date
Check all of the programs that apply: ☐ Medicaid ☐ Hawki ☐ Facility		

To be completed by client

I designate _____ to act as my personal representative.
(Name of Person)

Relationship of personal representative to client:

- ☐ Child
- ☐ Spouse
- ☐ Friend
- ☐ Attorney
- ☐ Other (Please specify) _____

Client's Signature	Date