Department of HUMAN SERVICES

Dear

Re: Identity of

Please get the attached *Affidavit of Identity* completed for the person named above. It must be completed by someone (other than the person named above) who knows the identity of the person named above.

Please return this form by _____. If you need more time to return the form, please call me before the due date and let me know. If you do not return the form or ask for more time by the due date, Medicaid/***hawk-i*** or family planning benefits for this person may be canceled or denied. If you have any questions, please call me at the number listed below.

Thank you.

Sincerely,

_____
Income Maintenance Worker

_____
Phone

_____
E-Mail

Enclosure

Worker No. _____

State ID _____

Case No. _____

Iowa Department of Human Services

Affidavit of Identity

1. Information about the person needing to verify identity

The person's full name who needs to verify identity (please print)
The person's date of birth or age
Other identifying information about the person, e.g., sex, race, height, weight, eye color

2. Information about the person completing this form

Full name (please print)

I state that the above information is true and correct.

3. Signature

This affidavit is signed under penalty of perjury.

Signature of person completing form	Date