IOWA | Health and Human Services

Iowa Connected Provider/Organization/Program Request

Return this form to iowaconnectedhelpdesk@hhs.iowa.gov

Provider Information (Ex, Doctor, Nurse, from the Community)

Provider Full Name: _____

Provider Credentials (i.e., RN, RDH, MD): _____

Provider Email Address: _____

Provider Phone Number: _____

Languages or Specialties: _____

Organization Information (Ex: Clinic, Hospital)

Name of Organization: _____

Organization Phone Number: _____

Organization Website: _____

Organization Address: _____

Organization Type (i.e., hospital, clinic) _____ County: _____

Program Information (Ex, Food Pantry in an organization, not your agency)

Name of Program: _____

Organization Program is Associated with: _____

Address of Program: _____

County of Program: _____

Note: The information provided on this form will appear in the Iowa Connected search function. Please be as accurate as possible and provide as much information as possible.