

Additional Correspondence Recipient Request

You can allow a person or facility to receive copies of your Department of Health and Welfare notices.

Contact the Department

Mail: P.O. Box 83720, Boise, ID 83720-0026
Phone: 1-877-456-1233
Fax: 1-866-434-8278
Local office: healthandwelfare.idaho.gov

Your Information

1. First Name	Middle Name	Last Name	2. Date of birth	3. Case Number
4. Social Security Number	5. Daytime Phone	Phone type (choose one) <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell		6. Alternate Phone Number
7. Physical Address		City	State	Zip Code
8. Mailing Address (if different)		City	State	Zip code

Tell us more about the request

The undersigned customer authorizes the Person or Facility (check one) listed below as an additional correspondence recipient to receive copies of notices from the Department of Health and Welfare.

Mark all programs you wish to authorize for the additional correspondence recipient:

Food Stamps Health Coverage AABD Cash TAFI

Additional Correspondence Recipient Information

1. Recipient First Name	Recipient Middle Name	Recipient Last Name	2. DBA Facility Name (If applicable)	
3. Mailing Address		City	State	Zip code
4. Physical Address		City	State	Zip Code
5. Date of Birth (If applicable)	6. Social Security Number (If applicable)	7. Daytime Phone	8. Provider Phone (If applicable)	

Signature (must be completed)

The form is not valid without the customer's signature.

Customer Signature

Date