Sharing Facts About Me and My Case

Section I

Case Name	Case No. (if any)

By signing this form, I understand _____ is helping me apply for HHSC benefits by allowing me to:

- use a computer that connects to the Texas Health and Human Services Commission's (HHSC) Your Texas Benefits website. I can use this website to apply for HHSC benefit programs such as SNAP, TANF, Medicaid and the Children's Health Insurance Program (CHIP).
- work with staff or volunteers who will help me understand and apply for HHSC benefits through the Your Texas Benefits website. I know that when I am applying through the website, I may need to share facts about myself and my family, including facts about my health, with the agency listed above so they can help me fill out and submit the application form.
- use other equipment I may need to apply through the Your Texas Benefits website. This other equipment may be a printer, copy machine, fax machine, phone or paper scanner. I understand that by using these items I may need to share facts about myself and my family, including facts about my health and my case, with staff or volunteers for the agency listed above.
- work with staff or volunteers who will help me find facts about my case or my application using the Your Texas Benefits website. This includes help finding the status of my application and facts about HHSC benefits I'm getting, including when my benefits will start or end. I understand that to get this help I will need to share with staff and volunteers my username, Social Security Number or case number, and I may need to share facts about myself and my family, including facts about my health and my case.

I understand that the agency listed above is acting on my behalf and is not acting on behalf of HHSC.

I know that I do not have to sign this form to:

- apply for HHSC benefits.
- be approved for HHSC benefits.
- get services through HHSC benefits.

However, I understand that to get help applying for HHSC benefits from the Community Partner agency listed above, I must understand what's in this form and sign it.

_____ _____
My Signature Date

Section II

I authorize HHSC to share facts about my case with the following person or agency. I understand the facts about my case may include private facts about my health.

Case Name: _____

Community Partner Agency (if any): _____

Address: _____

City, State, ZIP Code: _____

Telephone No.: _____

Check one of the following:

☐ Share all of my case record ☐ Share only the following facts from my case record:

Reason for sharing case record:

This agreement ends on _____.
(Give date or describe when you want your permission to stop)

Signature Section

_____ _____
My Signature Date

☐ If you are signing as the Legally Authorized Representative (defined as those persons listed below) of the person whose case record is being shared, check the box next to the phrase that best describes your authority to act for the person. We also may need to see proof of this relationship.

- ☐ A parent or legal guardian if the person is a minor.
- ☐ A legal guardian if a judge has ruled the person is not competent to manage their own personal affairs.
- ☐ An agent named as the person's durable power of attorney for health care.
- ☐ The person's court-appointed attorney ad litem.
- ☐ The person's court-appointed guardian ad litem.
- ☐ A personal representative or statutory beneficiary if the person is deceased.
- ☐ An attorney retained by the person or by another person listed on this form.
- ☐ If the person is deceased, their personal representative must be the executor, independent executor, administrator, independent administrator or temporary administrator of the estate.

Note: If you cannot sign your name, you must make a mark (X) and two witnesses to that mark must sign below. We can accept one witness signature in cases where it is not possible to get two witness signatures but you must document the reason in the case record.

_____ _____
Witness Signature Date

_____ _____
Witness Signature Date

Section III

You can change your mind. You can withdraw permission and tell us you do not want the agency listed above to share facts about your health or your HHSC benefits case, unless the agency listed above has already shared those facts based on your permission. You must withdraw your permission in writing to the Community Partner at: _____.
(Community Partner Address)