Texas Health and Human Services Commission
P.O. Box 149024
Austin, TX 78714-9024
Fax Number 1-877-HHSC-TEX (1-877-447-2839)

| Date | Case Number | Medicaid EDG Number |
|---|---|---|
| | | |

Name
Address Line 1
Address Line 2
City, State ZIP Code

You are enrolled in the Texas Women's Health Program and will receive services through **YYYY/MM/DD (insert the year, month and day of the last certification month)**. This Medicaid program provides gynecological exams, related health screenings and birth control.

If you want to continue receiving benefits for another year, complete, sign and return this form by **YYYY/MM/DD (insert the year, month and first day of the last certification month)** in the postage-paid envelope included in this mailing, or fax it to 1-877-HHSC-TEX.

After we review your information, we will send a letter letting you know if you qualify for another year of benefits.

If you have any questions, call us toll free at 2-1-1, Monday through Friday, 8 a.m. to 8 p.m. Central Time, or contact us by mail or fax at the address or number listed above.

**Please answer the following questions:**

- Are you pregnant? ☐ **Yes** ☐ **No**
- Are you sterile, infertile or unable to get pregnant due to medical reasons? ☐ **Yes** ☐ **No**
- Do you have health insurance that covers family planning services? ☐ **Yes** ☐ **No**
  - If yes, will filling a claim on your health insurance cause physical, emotional or other harm from your spouse, parents or other person? ☐ **Yes** ☐ **No**
    - If yes, explain your situation below. If needed, attach additional pages and include your name and Social Security number.

Signing up to vote:

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

**If you are not registered to vote where you live now, would you like to apply to register to vote here today? .....**☐ **Yes** ☐ **No**

**If you do not check either box, you will be considered to have decided not to register to vote at this time**. If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private. If you believe that someone has interfered with your right to register or to decline to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Elections Division, Secretary of State, P.O. Box 12060, Austin, TX 78711. Phone: 1-800-252-8683.

**Agency Use Only: Voter Registration Status**

☐ Already registered ☐ Client declined ☐ Agency transmitted ☐ Client to mail ☐ Mailed to client ☐ Other

Agency staff signature _____

**I wish to continue receiving Texas Women's Health Program benefits. I understand that I may qualify for other Medicaid services and I can apply at any time.**

| _____ | _____ | _____ |
|---|---|---|
| Signature | Date | Telephone Number (Provide a telephone number where you can discuss confidential information.) |