TEXAS
Health and Human Services

To:		From:	

The individual listed below is being considered for assistance. A signed authorization to furnish information is enclosed. Please provide the following information on the retirement benefit received by:

Name	Payee (if different)
Address	
Railroad Retirement No.	Social Security No.

Comments:

Area Code and Telephone No.

Signature–Eligibility Worker

Date

To be Completed by Railroad Retirement Board Representative:

Effective Date	Gross Monthly Amount	Monthly Medicare Amount	Other Deductions or Additions Amount*	Net Monthly Check Amount

*Explanation of Deductions or Additions:

Comments:

Area Code and Telephone No.

Signature–Railroad Retirement Board Official

Date