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 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 Telephone No.

Signature–Railroad Retirement Board Official Date