County Indigent Health Care Program
Confidentiality Agreement

Staff Member's Name (Type or Print)	Title (Type or Print)
County	Telephone Number (Including Area Code)

The following agreement exists to ensure confidentiality, integrity, and continuity of information resources. This agreement applies to all information accessed through the Automated Inquiry System (AIS) or Texas Medicaid & Healthcare Partnership (TMHP).

Please read the following agreement thoroughly. Complete, sign, and date this form. Keep a copy for your records. Return the original to the Texas Department of State Health Services, County Indigent Health Care Group Y- 990, PO Box 149347 Austin, TX 78714-9347.

I understand and agree that I may receive client-sensitive information from AIS/TMHP.

I understand and agree that I will use only AIS/TMHP to obtain the status of Medicaid eligibility dates in regards to the County Indigent Health Care Program.

I understand and agree that I will use only the assigned County Provider Identifier number to access AIS/TMHP.

I understand the importance of confidentiality and agree to keep any information received confidential.

I agree not to disclose any information to anyone or allow anyone to use this information.

I understand that I am responsible for my actions and the actions of any county staff member who may receive this information and who is under my direct control and supervision.

I understand and agree that in the event of an audit by Health and Human Services Commission (HHSC) and/or Texas Department of State Health Services (DSHS), the County will make available all documentation regarding Medicaid Reimbursement upon request.

I understand and agree that any questions concerning the appropriateness of the release of data will be processed according to DSHS policies and procedures for release of open records.

Staff Member's Signature _____ Date _____

County Judge Signature _____ Date _____