Texas Residence Form for Former Foster Children Medicaid
5/10/17 version

Please complete this form if *Former Foster Youth Name* is a resident of Texas so they can continue to have Texas Former Foster Care Children Medicaid. This form can be completed by anyone familiar with *Former Foster Youth Name*'s situation that **is not related to them** including:

- A neighbor or friend
- Someone from school or job
- Any agency or shelter the who provides services
- The person they are staying with if they are not related
- A Preparation for Adult Living (PAL) or Aftercare worker.

Texas Health and Human Services Commission
PO Box 149025
Austin, TX 78714-9025
Fax: 1-877-447-2839

Re: Former Foster Care Children's Medicaid Renewal; *Former Foster Youth Name. DOB (pre-filled)* xx/xx/xxxx, Case # *(pre-filled)* XXXXXX

My name is _____and I am the _____

_____ (describe relationship) of *Former Foster Youth Name*. I am not related to them.

Former Foster Youth Name currently lives in Texas.

Former Foster Youth Name receives mail at the following address: _____

_____.

My phone number is: _____ and my address is: _____.

Sincerely,

_____
Signature

_____
Date

Return form by fax to 1-877-447-2839 or mail to: Texas Health and Human Services Commission, PO Box 149025, Austin, TX 78714-9025.