THE TEXAS HEALTH INFORMATION, COUNSELING AND ADVOCACY PROGRAM

APPLICATION FOR CERTIFICATION

NAME: ______________________________

ADDRESS: ______________________________

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PHONE NO.: ______________________________

AREA AGENCY: ______________________________

I request approval to become *certified* *re-certified* (circle one) as a Benefits Counselor I, Benefits Counselor II or Long Term Care Certification (circle one) for the Texas Health Information, Counseling and Advocacy Program. I agree to abide by the rules, policies and procedures governing this program, including reporting requirements, as set forth by the Texas Department on Aging and Disability Services. I agree to accept supervision and direction from the area agency and its staff benefits counselor. I agree to perform my duties in a consistent and faithful manner and to maintain the need and rights of older people as a priority for my efforts.

I understand the need to maintain confidentiality of any and all personal information I receive in the course of my duties as benefits counselor.

I agree to notify the staff benefits counselor and area agency of any conflicts of interest that exist or may develop during the course of my duties.

I understand that I may be re-certified by showing evidence of my commitment to the required continued training and by mutual consent of the area agency. I further understand that this agreement may be terminated by either party by written notification.

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DATE **BENEFITS COUNSELOR APPLICANT SIGNATURE**