



*Just Ask*

210-477-3275

**Alamo Service Connection  
Bexar Area Agency on Aging  
8700 Tesoro Drive Suite 700  
San Antonio, TX 78217**

**Client Information Form**

**Today's Date** \_\_\_\_\_

**Client Name:** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

**Address** \_\_\_\_\_  
Street City State ZIP

**Telephone:** \_\_\_\_\_  
Home Cell Work

**Insurance Information:**  
**Medicare Number** \_\_\_\_\_ **Effective Date: A** \_\_\_\_\_ **B** \_\_\_\_\_

**Do You Have Medicaid?** \_\_\_\_\_ **Medicaid Number** \_\_\_\_\_

**Do You Have A Medicare Advantage Plan?** \_\_\_\_\_

**Do You Have Prescription Drug Coverage?** \_\_\_\_\_

**How did you hear about our services?** \_\_\_\_\_

**Have you received services before from our organization?** \_\_\_\_\_

**Income:**

**Your Monthly Income** \_\_\_\_\_ **Source** \_\_\_\_\_

**Your Spouse's Monthly Income** \_\_\_\_\_ **Source** \_\_\_\_\_

**Signature** \_\_\_\_\_

**Signature of Benefits Counselor** \_\_\_\_\_ **Time** \_\_\_\_\_





## CLIENT AGREEMENT

I understand that the Texas Health, Information, Counseling and Advocacy program is a state sponsored, non-profit program for persons needing assistance with their public and/or private benefits. Counseling services are intended to help me understand public and private benefits in an objective manner that supports my independent decisions. I understand that counseling services are provided by Benefits Counselors, acting in good faith to provide information about public/private benefits to me, the client.

I understand that Benefits Counselors are not permitted to render legal advice or other legal services which would be construed as the unauthorized practice of law. I understand that Benefits Counselors are neither affiliated with the insurance industry, nor are they financial planners. They do not sell, recommend or endorse any specific insurance product, agent, insurance company or Health Maintenance Organization.

Counseling is confidential and free of charge. I understand that I may make a donation to the program if I desire.

Furthermore, I authorize the Bexar Area Agency on Aging, to receive information as necessary, from other agencies or provider of services from which I'm receiving services, to complete the course of action needed regarding my public/private benefits. Such authorization shall remain valid for one year, from the date of signature or at such date that the file is closed.

X \_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Counselor Signature

X \_\_\_\_\_  
Date

\_\_\_\_\_  
Date