CONFIDENTIALITY AGREEMENT

I, _____,
(title) _____ am an employee of and/or acting on behalf of _____ as an agent for the _____County Department of Social Services. I understand that all communications, information and documents received by me in the course of business as an agent certifying and copying original documents for Medicaid/Family Health Plus applications are confidential and may not be disclosed by me to unauthorized personnel or used for any purpose other than assisting individuals for the purpose of applying for or recertifying for Medicaid/Family Health Plus.

I have read this Confidentiality Statement and understand that any violation of the provisions of this agreement is unlawful and may subject me to loss of my status to review and copy original or certified copies of identity/citizenship documents, as well as any other penalties prescribed by law.

_____
Signature

_____
Print Full Name

_____
Date

_____
Witness