Rulemaking Notification Form

1. *Originating agency completes this form as soon as the agency recognizes the need for a rule change.*
2. *Originating agency submits this request with **the initial rule packet** to the appropriate HHS Senior Policy Advisor advising the entity after all internal agency development and review processes are completed.*
   (See Step 1 in Rulemaking Process.)

Agency Unit/Section/Division			
Agency Program Contact	E-mail Address	Telephone No.	Mail Code
Agency Attorney Contact	E-mail Address	Telephone No.	Mail Code

1. This project involves *(check all that apply):* ☐ New Rule ☐ Rule Amendment ☐ Repeal of a Rule

2. Description *(include applicable rule or chapter numbers and a description of planned rule project):*

3. Is this a Medicaid rule? ☐ Yes ☐ No

4. Rule initiated in response to: *(check all that apply)*

Legal Mandate	Citation or Name of Case	External Request	Internal Request
☐ State law		HHSC	Executive directive
☐ Federal law		Advisory Council	Policy clarification
☐ Lawsuit		Advocates	Field request
		☐ Providers	State office program initiative
		☐ Other agency:	
☐ Other:			

5. Provide additional information that would be helpful to understand the issue *(business need for the rule, background, need for anticipated public comment, budget implications, etc.):*

6. What other areas (within **originating agency** and **HHS enterprise**) may be affected by this rule project?

7. When should the rule become effective? *(check only one)*

- ☐ Required effective date: ____________ What authority requires this date? ____________
- ☐ Preferred effective date: ____________
- ☐ No specific required or preferred effective date. (schedule to be determined)

Originating Agency Program Contact (original signature on file)	Date
Center for Policy Innovation or HHS Senior Policy Advisor (original signature on file)	Date
Agency Deputy Commissioner or HHS Deputy Executive Commissioner (for HHSC rules) (original signature on file)	Date