Department of Health & Human Services
DHHS
NEBRASKA

Division of Children and Family Services

Application for Benefits

(Application is available in Spanish-Solicitud disponible en español)

The attached application can be used to apply for any of the following programs.

Supplemental Nutrition Assistance Program (SNAP) formerly known as Food Stamp Program (FSP)

SNAP assists households with limited assets and income to buy the food they need for good health. Households qualify for SNAP benefits based on available household assets, income and certain expenses. If the household is eligible, SNAP benefits are placed on an Electronic Benefits Transfer (EBT) card for the household to buy food.

SNAP follows regulations and rules established by the federal government.

Aid to Dependent Children (ADC)

The ADC Program provides money payments and/or medical coverage to eligible parents and dependent children age 18 or younger who qualify because the family has little or no income. Participation in Employment First may be required.

Employment First (EF) is the name of Nebraska's welfare reform program. The goal of EF is to help families achieve economic self-sufficiency through training, education, and employment preparation. EF is designed to assist families through the transition from welfare to the work force.

Low Income Home Energy Assistance Program (LIHEAP)

The Energy Assistance Program may help an eligible household with some of their winter heating bills, utility shut-offs, empty or low heating fuel tanks, utility deposits, air conditioning, and the repair or replacement of a furnace.

Child Care (CC)

The Child Care Program assists eligible parents and caretakers in paying for the cost of child care while they work, attend employment-related training or school, or participate in another approved activity.

Based on their income the family may be responsible to pay for a portion of the cost.

Kids Connection (KC)

A Medicaid program for qualified children under 19 years of age.

Refugee Resettlement Program (RRP)

The RRP may provide financial and medical assistance to persons who are not eligible for other programs to achieve economic self-sufficiency. Assistance may be available to single adults or childless couples in the first 8 months after their arrival in the United States.

Medicaid

Nebraska's Medical Assistance Program (Medicaid) can help pay for certain health care services for eligible families and individuals which include the following:

- Parent(s) with dependent minor children;
- Children under 19 years of age;
- Pregnant women;
- Aged, Blind and Disabled persons.

Assistance to the Aged, Blind and Disabled (AABD)

The AABD Program provides money payments and/or medical coverage to individuals or couples who:

- Are age 65 or older;
- Have been determined to be permanently and totally disabled or permanently and totally blind;
- Have a temporary disability that will last at least 6 months;
- Need help paying their Part B Medicare Premium.

NOTE: Individuals are not eligible for both the "Blue Cross/ Blue Shield" Comprehensive Health Insurance Pool (CHIPs) and Medicaid at the same time.

Child Support Enforcement (CSE)

Anyone who has a child and needs help in establishing paternity will receive CSE services. Child Support Enforcement will also assist in establishing a court order, and/or collecting current or past due child support payments.

Other Services

Other services available to allow an eligible person to remain in their own home:

- Personal Assistance Services
- Chore
- Transportation
- Adult Day Care
- Meals
- Respite

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EA-117 Rev. 12/10 (56084)
(Previous version 8/10 should be used)

Go online: ACCESSNebraska.ne.gov

- Do I qualify?
- Apply for benefits
- Report changes
- Benefits Inquiry

Answer all the questions listed on the application. Many questions are "Yes" or "No".
You may be asked to provide more information.

- You must complete the entire application before we can determine your eligibility
- You may turn in an application with only your name, address, and signature on Page 2. An authorized representative may sign for you. If you turn in an application we will contact you.
- Social Security Numbers are only required on those who will receive assistance/benefits. For example: Kids Connection Program, the Social Security number is required on the children who are applying to receive medical assistance.
- Citizenship and legal status information is required for those who will receive assistance/benefits. For example: Medicaid program, the citizenship and legal status information is required on those who will be covered by the medical assistance.
- For SNAP benefits, we will issue your benefits based on the date we receive your application. (If in an institution on the date of application, the received date is your date of release from that institution).
- Households eligible for expedited service may receive SNAP benefits within 7 days.
- Households not eligible for expedited service may receive SNAP benefits within 30 days.

Different programs require proof of some or all of the sources listed below:

Household members – birth certificates or proof of identification, age, and family relationships, Social Security Numbers (SSNs). Citizenship or immigration status may be required for those individuals in the household that are applying for benefits.

Resources – checking and savings accounts, stocks and bonds, certificates of deposits, retirement accounts including IRAs and Keogh Plans, property owned other than the home you live in, automobiles (includes trucks, motorcycles, ATVs, trailers, boats and airplanes).

Income – check stubs from employment (includes jobs left within the last 90 days), ledgers and income tax returns from self-employment including farming, child support or alimony, Social Security income, pension, unemployment benefits, interest or dividends, student income (work study, graduate assistance, fellowships, stipends).

Expenses – House or rent payment, lot rent, utilities, medical expenses including health insurance, child support payments and child care or dependent care payments.

Visit our Website at: www.dhhs.ne.gov

- To find more information on the programs offered
- To find an online application that may be printed and completed
- To find an address for your local Nebraska Department of Health and Human Services (DHHS) office

Department of Health & Human Services
DHHS
NEBRASKA

Division of Children and Family Services

Application for Benefits

Instructions to file an application for benefits:
Answer the questions and sign this application, then take, mail or fax this application to a Nebraska Department of Health and Human Services Office (DHHS). This becomes a valid application once you enter your name and address, sign the form and return it to a DHHS Office. You may have someone help you complete this form, or you may contact a DHHS office for help.

1. If you need us to provide an interpreter, check here ☐ What language?_____

2. This application is used for the multiple programs listed below. Please mark all you wish to apply for (DHHS determines eligibility for each program separately your application will be processed according to program policy and procedures, established timeliness and notice requirements).

☐ Aid to Dependent Children (ADC) - List names:_____

☐ Aid to Aged, Blind & Disabled (AABD) - List names:_____

☐ Child Care (CC) - List names:_____

☐ Energy Assistance for Utilities (LIHEAP) - List names:_____

MEDICAID:

☐ Children (KC) - List names:_____

☐ Adult - List names:_____

☐ Supplemental Nutrition Assistance Program (SNAP) (formerly known as Food Stamp Program (FSP)

List names: _____

☐ Refugee Resettlement Program (RRP) - List names:_____

☐ Social Services Block Grant (SSBG) (includes Personal Assistant Services, Chore, Transportation, Meals, Adult Day Care, and Respite) - List names:_____

3. Do you have a Nebraska Electronic Benefits Transfer (EBT) card for SNAP benefits?
☐ Yes ☐ No

4. Expedited Service: If you answer yes to any of the questions below, you may qualify for expedited SNAP benefits. Expedited benefits cannot be issued until an interview is conducted and your identity is verified. If you meet the expedited standards below you may be eligible to receive SNAP benefit within 7 days.

☐ Yes ☐ No 4a. Is your total household income for the month of application less than $150 before deductions?
☐ Yes ☐ No 4b. Is your total household cash/savings for the month of application less than $100?
☐ Yes ☐ No 4c. Do your total shelter costs exceed your monthly income and resources?
☐ Yes ☐ No 4d. Are members of your household migrant or seasonal farm workers whose cash and savings are $100 or less?

5. Answer Yes or No for each line.

☐ Yes ☐ No 5a. Do you have an eviction notice?
☐ Yes ☐ No 5b. Have your utilities been shut off or do you have a shut off notice?
☐ Yes ☐ No 5c. Are you out of heating fuel (propane, oil)?
☐ Yes ☐ No 5d. Do you need help with food right now?
☐ Yes ☐ No 5e. Do you need any other help right now? If yes, tell us what you need in the space below:

_____

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6. Applicant/Head of Household information*:

Name(First, Middle, Last) _____

Birthdate (Month, day, year)_____ Social Security No**_____

Address where you live_____

City:_____ County_____ State_____ Zip_____

Mailing address (if different from above)_____

City:_____ County_____ State_____ Zip_____

Telephone No_____ Message No_____

Signature_____ Date_____

*Designation of **Head of Household*** for SNAP. If your household has more than one parent, you must tell us which parent should be designated as "Head of Household". In households without children, the "Head of Household" must be the person who has the greatest amount of earned income in the previous two months.

**A Social Security Number is not required to apply for Medicaid, Kids Connection (KC), Child Care Assistance (CC), Social Services for the Aged, Disabled (SSAD) and Social Services for Children and Families (SSCF).

FOR OFFICE USE ONLY

For MED Cases Only: Request date:_____

7. Complete this section for yourself and everyone who lives with you, even if they are not applying. Attach another sheet if more space is needed.

Name (List yourself first) Last name, first name	Relationship to you. (If not related write "NR")	Birthdate (Month, day, year)	Age	Gender* Male (M) Female (F)	Social Security Number**	Does this person eat with your family? Yes	Does this person eat with your family? No	Is this person disabled or blind? Yes	Is this person disabled or blind? No	Marital Status* & effective date
	SELF									

*Gender and Marital Status are not required if applying for SNAP benefits only.
**Social Security Number is required only for those individuals applying for benefits. For Medicaid it is the person to be covered by medical assistance.

8. List any previous names used including maiden name:_____

9. Please mark your living arrangement:

- ☐ Live in a house - rent/own/mortgage
- ☐ Rent an apartment, duplex, triplex
- ☐ Rent a room
- ☐ Board and room situation
- ☐ Adult Family Home
- ☐ Center for Developmentally Disabled
- ☐ Assisted Living
- ☐ Nursing home
- ☐ Drug abuse or alcohol treatment center
- ☐ Battered spouse shelter
- ☐ Group home, foster care, child care institution
- ☐ Other:_____

10. Previous address if you or anyone in your household has moved in the last 30 days:

Address:_____ City:_____ State:_____ Zip code:_____

11. Emergency contact:

Name:_____ Phone number:_____ Relationship:_____

12. Are you requesting assistance for anyone in your household who is pregnant?
☐ Yes ☐ No If yes, give us the following information:

Name:_____ Expected Date of Delivery:_____

13. Do you or does anyone in your household applying for or receiving help have a Guardian, Conservator, or individual acting under Power of Attorney?
☐ Yes ☐ No If yes, give us the following information:
Name of person with Guardian, Conservator or Power of Attorney:_____

Name of Guardian, Conservator, or Power of Attorney:_____ Phone number:_____

Address:_____ City:_____ State:_____ Zip code:_____

13a. Does Guardian/Conservator receive payment for his/her services?
☐ Yes ☐ No

14. **OPTIONAL**- Indicate the race and ethnic category of the head of household. Title VI of the Civil Rights Act of 1964 allows us to ask for this information. This information will not be used in determining eligibility for assistance. If you do not provide this information, it will not affect your application. We ask for the information to assure that benefits are distributed without regard to race, color, ethnicity or national origin. If you do not enter any information, the worker will enter an answer.
Race - Select all that apply:
☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other:_____
Ethnic Category - Are you Hispanic or Latino? ☐ Yes ☐ No

15. Complete this section for yourself and everyone who lives with you, that is applying for assistance. For (**Medicaid)** and **(Kids Connection)** this is the person being covered by the medical assistance. Attach another sheet if more space is needed.

Name (Last name, first name)	I am a US Citizen		If US Citizen, list where born	I am a qualified alien under the federal Immigration and Nationality Act		If qualified alien, list immigration status and alien number
	Yes	No		Yes	No	
1.						
2.						
3.						
4.						

NOTE: If a qualified alien - I agree to provide a copy of my USCIS documentation to the Department of Health and Human Services, upon request.

16. Did you or anyone in your household receive assistance from another state (for example: cash assistance, medical assistance, or SNAP benefits) in the last three months?
☐ Yes ☐ No If yes, give us the following information:

Who	Type of assistance	When (month & year)	Where (state & county)	Caseworker (name & phone number)
1.				
2.				

16a. OPTIONAL - Do you or does anyone in your household receive Native American tribal commodities?
☐ Yes ☐ No If yes, who:_____ When:_____

17. Answer Yes or No for each line.

Have you or has anyone in your household ever been disqualified in one of the following programs: (Example of disqualification: intentionally provide false information, etc.)?

☐ Yes ☐ No Supplemental Nutrition Assistance Program (SNAP)

☐ Yes ☐ No Aid to Dependent Children (ADC)

☐ Yes ☐ No Child Care (CC)

If yes, give us the following information:

Name of person disqualified	Where did it happen? (county & state)	When did it happen? (month & year)	For how long (6 months 1, 2, or 10 years OR permanently)?

18. Answer Yes or No for each line.

Are you or is anyone in your household currently:

☐ Yes ☐ No a. Fleeing to avoid prosecution or custody/confinement after conviction for a felony crime?

☐ Yes ☐ No b. In violation of probation or parole?

If yes, give us the following information:

Who	What	When	Where
			State: County:

19. Answer Yes or No for each line.

Have you or has anyone in your household:

☐ Yes ☐ No a. Been charged and convicted of a felony (after August 22, 1996) for possession, sale, use, or distribution of a controlled substance? A “controlled substance” is an illegal drug or certain drugs that require a doctor’s prescription.

☐ Yes ☐ No b. Been found to have misrepresented identity or residence in order to obtain multiple benefits at the same time after September 22, 1996?

☐ Yes ☐ No c. Been found guilty of buying or selling SNAP benefits of $500.00 or more after September 22, 1996?

☐ Yes ☐ No d. Been convicted of using and/or receiving SNAP benefits in exchange for firearms, ammunition, or explosives after September 22, 1996?

☐ Yes ☐ No e. Been convicted of trading SNAP benefits for drugs after September 22, 1996?

If yes, give us the following information:

Who	What offense	Date of offense	Where
			State: County:

A. RESOURCES

20. Do you or does anyone in your household have any of the following resources? Include children. This includes resources that your name or any household member's name appears as an owner.

☐ Yes ☐ No

- If yes, write the value on the line.
- If left blank, no amount listed, this means no one in your household owns these resources.
- Attach another sheet of paper if more space is needed.

401K $ _____

Annuities $ _____

Burial Funds/Trusts/Spaces $_____

Cash $ _____

Checking $ _____

Certificates of Deposits $ _____

Credit Union Accounts $_____

Crops/Livestock $ _____

RealEstate/Real Property/Farmland $ _____

Debit/Prepaid Card Account $ _____

Child's Account $ _____

Child's Account $ _____

IRA $_____

KEOGH $_____

Machinery $_____

Savings $ _____

Savings Bonds $ _____

Life Insurance $ _____

Nursing Home Account $_____

Investments/Other $_____

21. Does your name or does anyone in your household's name appear on the title of any licensed or unlicensed vehicles (includes cars, trucks, motorcycles, ATVs, boats, RVs, snowmobiles, trailers, aircraft, etc.)? Attach another sheet if more space is needed.

☐ Yes ☐ No If yes, give us the following information:

Owner	Type of vehicle	Make/Model	Year	Value	Amount owed
1.				$	$
2.				$	$
3.				$	$

22. Have you or has anyone in your household sold, traded or given away anything of substantial value within the past 60 months (five years)? If you are applying for SNAP benefits only, list any items sold, traded or given away in the last three months. Attach another sheet if more space is needed.

☐ Yes ☐ No If yes, give us the following information:

Owner	What was sold, traded or given away	When	Value
1.			$
2.			$
3.			$

B. INCOME

23. Do you or does anyone in your household work? Work includes employment and self-employment. Self-employment could be farming, odd jobs, provided child care, housekeeping, etc.:

Does any Adult or Child Currently Receive any Money from:	Yes	No	If Yes, Who is it?	Employer Name or Income Source	Gross Amount (before deductions)	How often received?	Hourly Rate
1. Salaries, Wages, Tips, Commissions, etc., (Provide pay stubs for each adult)				Business Name: _____ Address: _____			
2. Salaries, Wages, Tips, Commissions, etc., (Provide pay stubs for each adult)				Business Name: _____ Address: _____			
3. Self-Employment Income (Include your most recent Federal Tax Return with 1040 and all schedules)				Business Name: _____ Type of Business: _____ Address: _____ Date Started: _____			

NOTE: You are allowed to claim certain costs of doing business (expenses) to apply against your self-employment income. These costs can be obtained from tax returns or self-employment ledgers. DHHS will explain which of these documents (tax return or ledgers) you will need to provide to identify the allowable costs of doing business.

24. Have you or has anyone in your household left a job or reduced work hours in the last 60 days?
☐ Yes ☐ No If yes, give us the following information:

Name	Employer information	Date of change (month, day, year)	Reason Job Ended
1.	Name: Address:		☐ Laid Off ☐ Quit ☐ On Strike ☐ Resigned ☐ Terminated
2.	Name: Address:		☐ Laid Off ☐ Quit ☐ On Strike ☐ Resigned ☐ Terminated

C. OTHER INCOME

25. Have you or has anyone in your hosuehold applied for or are you or is anyone in your household receiving other income that is not from working? Include children:
☐ Yes ☐ No

If yes, give us the following information:

- Write the monthly amount received and who receives it on the line.
- If anyone has applied to receive these benefits, but does not receive them yet, write "Applied" on the line.
- If left blank, no amount is listed or "Applied" is not written in, this means no one receives nor plans to receive these monies.

Attach another sheet of paper if more space is needed. .

SSI $_____ Civil Service $ _____

Social Security $_____ Interest/Dividend $_____

Pension/Retirement $ _____ Railroad Retirement $ _____

Veterans Benefits $_____ Military Allotment $ _____

Cash Assistance Payments $_____ Rental Income $_____

Workers Compensation $ _____ Claims/Disability $_____

Unemployment Compensation $ _____ Insurance/Accident Settlement $ _____

Child Support/Alimony $_____ Child Support/Alimony $ _____

Farm Income $ _____ Striker Income $ _____

Annuities $ _____ Life Estates $ _____

Trusts/Inheritances $ _____ Partnerships/Corporations $ _____

Native American Benefits $ _____ Prizes/Awards/Winnings/Lottery $ _____

Gifts/Money from Relatives or Friends $ _____ Contributiions $ _____

D. HOUSING & UTILITIES

NOTE: SNAP: Failure to report or verify an expense other than rent or utilities will be seen as a statement by your household that you do not want to receive a deduction for the unreported and/or unverified expense.

26. Are you or is anyone in your household billed for the following expenses? If yes, give us the following information: If left, blank - you do not have that expense.

Expense	Amount currently billed	Who pays this bill (List names of anyone who helps pay this bill)	How often billed
a. Rent Landlord's name: Phone number:		 Is this public/subsidized (Section 8) housing? ☐ Yes ☐ No	
b. Mortgage			
c. 2nd Mortgage			
d. Lot rent			
e. Property taxes on home (if not included in mortgage)			
f. Homeowners Insurance (if not included in mortgage)			
g. Condominium/Association fees			
h. Other_____			

27. Do you or does anyone in your household receive a bill for heating and/or cooling (air conditioner)?
☐ Yes ☐ No If yes, which of the following is your main source of heating and/or cooling?
☐ Electrical/Heat ☐ Electrical/Cool ☐ Kerosene ☐ Natural Gas
☐ Coal ☐ Fuel Oil ☐ Wood & other sources ☐ Propane

Heating Supplier:	Cooling Supplier:
Name:	Name:
Address:	Address:
Account Number:	Account Number:

28. If you answered "No" to question #27, are you or is anyone in your household billed for any of the following:
Answer Yes or No for each line.

☐ Yes ☐ No Electricity for other than heating or cooling
☐ Yes ☐ No Natural Gas/Fuel Oil/Kerosene/Propane for other than heating or cooling
☐ Yes ☐ No Maintenance for wells and septic tank
☐ Yes ☐ No Water
☐ Yes ☐ No Sewer
☐ Yes ☐ No Trash/Garbage Collection
☐ Yes ☐ No Telephone

29. Did you or did anyone in your household receive help in paying heating and/or cooling bills in the last 12 months?
☐ Yes ☐ No If yes, give us the following information:

Who paid? Low-Income Home Energy Assistance Program (LIHEAP) or someone else?	Name & address of where you lived when you received this assistance

E. OTHER EXPENSES

30. Are you or is anyone in your household **paying** child support? Attach another sheet of paper if more space is needed.
☐ Yes ☐ No If yes, give us the following information:

Who pays	Court order#	State & county issued	Amount ordered	Amount being paid	Is this an arrearage
					☐ Yes ☐ No
.					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

31. Are you or is anyone in your household **billed** for Child Care or dependent care?
☐ Yes ☐ No If yes, give us the following information:

Who provides care	Amount	How often billed
Name: Address:		
Name: Address:		

F. CHILD CARE

32. Do you currently have child care or do you need a child care provider?
☐ Yes ☐ No If yes, what is the reason you have or need child care:_____

33. In order to receive child care assistance, I agree to have my child(ren) receive shots to protect against diseases (such as measles, chicken pox) or infection in accordance with state immunization guidelines.
☐ Yes ☐ No If you marked no, please check the reason below:
☐ a. My religious beliefs do not allow shots; **or**
☐ b. These shots would harm my child's medical condition. (This requires a doctor's statement.)

G. SCHOOL

34. Are you or is anyone in your household attending school, including college?
☐ Yes ☐ No If yes, give us the following information:

Name	School name	School address	Attending full time or part-time	Grade/class attending
1.		Street: City: State:		
2.		Street: City: State:		
3.		Street: City: State:		

35a. If attending college or university, are you or is anyone in your household participating in work study?
☐ Yes If yes, list names:_____
☐ No

35b. Have you or has anyone in your household applied for or are you or is anyone in your household receiving a graduate assistantship, fellowship or stipend?
☐ Yes If yes, list names:_____Amount_____
☐ No

36. **This question applies only to those applying for ADC Cash Assistance:** List below all members of your household 16 years of age and older and the highest school grade they have completed:

Name	Highest grade completed	Name	Highest grade completed
1.		2.	
3.		4.	

H. MEDICAL

37. Do you or does anyone in your household owe medical bills from the past three months?
☐ Yes ☐ No If yes, give us the following information:

Name	What months	Name	What months
1.		2.	
3.		4.	

NOTE: It is important to provide this information now, as Medicaid may be able to help pay these bills.

38. Do you or does anyone in your household have medical problems or medical costs due to an accident?
☐ Yes ☐ No If yes, give us the following information:

Person's name:_____ Date of accident:_____

38a. Is there an attorney involved?
☐ Yes ☐ No
If yes, name of attorney:_____ Phone number:_____

38b. Is there an insurance company involved?
☐ Yes ☐ No
If yes, name of company:_____ Phone number:_____

39. Do you or does anyone in your household have Medicare (Social Security)?
☐ Yes ☐ No If yes, give us the following information :

Name	Medicare claim number	Name	Medicare claim number
1.		2.	

40. Are you or is anyone in your household a veteran, spouse of a veteran or a minor child of a veteran?
☐ Yes ☐ No
If yes, list names:_____

41. Are you or is anyone in your household covered by medical insurance? Examples: Medicare supplemental, health, hospitalization, accident or dental insurance. Include policies through work, military, or policies paid for by someone outside your household.
☐ Yes ☐ No If yes, give us the following information for each person and policy:

Name(s) of insured person(s)	Policy holder	Insurance company	Policy/group number	Premium paid
1.		Name: Address: Phone:		
2.		Name: Address: Phone:		

42. Do you or does anyone in your household who is disabled or age 60 or older, have medical expenses, which have not been paid in full by any other source, (including health insurance)? This may include medications, deductibles, co-pays, co-insurance and travel expenses to or from medical appointments.
☐ Yes ☐ No If yes, give us the following information:

Name	Who is owed or was paid	Amount owed or amount paid
1.	Name: Address: Phone:	
2.	Name: Address: Phone:	

NOTE: **Health Check**: The Nebraska Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a service available to all eligible Medicaid participants age 20 and younger.

43. Does anyone in your household age 20 or younger need a medical or dental examination?

☐ Yes ☐ No If yes, list name(s):_____

I. CHILD SUPPORT INFORMATION

44. For all children age 18 or younger (including any unborn): provide the following information for any child who has a parent not living in your household. Attach another sheet of paper if more space is needed.

Child's name (If unborn, write unborn)	Information for parent not living in your household	This parent's employer information	Does this parent's name appear on the birth certificate?	Did this parent sign a paternity acknowledgement?
A. Child's Name: Mom's marital status: and if married, list name of spouse,:	Name: SSN: Birthdate: Address: Phone: If deceased, date:	Name: Address: Phone:	☐ Yes ☐ No	☐ Yes ☐ No
B. Child's Name: Mom's marital status: and if married, list name of spouse:	Name: SSN: Birthdate: Address: Phone: If deceased, date:	Name: Address: Phone:	☐ Yes ☐ No	☐ Yes ☐ No
C. Child's Name: Mom's marital status: and if married, list name of spouse:	Name: SSN: Birthdate: Address: Phone: If deceased, date:	Name: Address: Phone:	☐ Yes ☐ No	☐ Yes ☐ No

OPTIONAL: Designating Authorized Representatives for SNAP Only

45. a. Do you want to choose a person to apply for SNAP benefits on your behalf? ☐ Yes ☐ No If yes, give us the following:

Name:_____

Address:_____

City/State/Zip:_____ Phone number:_____

b. Do you want to choose a person to use your SNAP benefits to buy food through your Electronic Benefits Transfer (EBT) card? ☐ Yes ☐ No If yes, give us the following:

Name:_____

Address:_____

City/State/Zip:_____ Phone number:_____

Voter Registration

46. Any citizen in the State of Nebraska who has met the voter registration requirements and applies for public assistance/ SNAP benefits must be provided the opportunity to register to vote. If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private.

☐ Yes ☐ No If you are not registered to vote where you live now, would you like to apply to register to vote today? If you did not check either answer, you will be considered to have decided not to register to vote at this time.

Page 18 must be signed for this application to be considered complete.

Child Support Enforcement (CSE)
1-877-631-9973

Eligibility Requirements

As a condition of eligibility, ADC, Foster Care and Child Care Subsidy recipients are required to receive CSE services and do not have the option to refuse any of these services. The CSE office will mail you a document that outlines your Rights and Responsibilities as they apply to the Nebraska CSE Program.

Medicaid recipients are required to receive CSE services related to securing medical support, including the establishment of paternity when appropriate. Medicaid receipients do have the option of refusing other CSE services, but the Medicaid recipient must notify CSE that they are requesting only IV-D services that relate to securing medical support.

Benefits of Child Support Services

Your cooperation with the Child Support Enforcement (CSE) Unit may be of value to you and your child because it could result in the following benefits:

- Establishing your child's paternity;
- Establishing/enforcing and collecting child and/or medical support judgments; and
- You and your child may qualify for future Social Security, veterans, other government benefits, or medical coverage.

What is Cooperation?

Cooperation includes any actions relevant to, or necessary for, the achievement of child support enforcement objectives. You are required to cooperate with Child Support Enforcement, unless good cause (see below) has been determined for not cooperating. You are required to cooperate with CSE in obtaining the following:

ADC recipients are required to cooperate with Child Support Enforcement in achieving the following objectives:

1. Identification and location of the parent(s)/alleged father of a child who receives ADC grant payments;
2. Establishment of paternity;
3. Establishment/enforcement of a support order;
4. Modification of a support order; and
5. Collection and distribution of support payments.

Medicaid recipients referred for child support services are required to cooperate with Child Support Enforcement in achieving the following objectives:

1. Identification and location of the parent(s)/alleged father of a child who receives medical assistance benefits;
2. Establishment of paternity;
3. Establishment/enforcement of medical support; and
4. Collection and distribution of medical support.

Child Care Subsidy recipients referred for child support services are required to cooperate with Child Support Enforcement in achieving the following objectives:

1. Identification and location of the parent(s) or alleged father of a child who receives child care subsidy benefits;
2. Establishment of paternity;
3. Establishment/enforcement of a support order;
4. Modification of a support order; and
5. Collection and distribution of support payments.

Good Cause Circumstances

You should contact your Child Support Enforcement worker immediately if at any time you believe that coooperation, or proceeding to establish or secure support is against the best interest of your child(ren), parent/needy caretaker relative, and/or guardian/conservator for whom support is sought. You will need to file a good cause claim in order to not cooperate with the child support requirements. The following are circumstances under which you may be exempt from the cooperation requirement:

- Cooperation is anticipated to result in serious physical or emotional harm to you or the child;
- The child was born as a result of forcible rape or incest;
- Court proceedings are pending for adoption of the child; or
- You are working with an agency helping you to decide whether to place the child for adoption.

Proving Good Cause

It is your responsibility to:

- Provide evidence needed to determine whether you should be exempt from the cooperation requirement.
- Give the necessary evidence to the agency within 20 days after claiming good cause.

The Child Support office may:

- Determine your claim based on the evidence which you give to the agency; or
- Decide to conduct an investigation to further verify your claim. If it is decided an investigation is needed, you may be required to give information, such as the non-custodial party's name and address, to help the investigation.
- If it is necessary to contact the non-custodial parent as a part of the investigation, the worker will inform the custodial party that such contact will be attempted.

If You Do Not Cooperate and You Do Not Have Good Cause:

You risk the penalties of:

- 25% reduction of your ADC grant, and
- No medical assistance for yourself
- Loss of child care subsidy benefits

Assignment of Support for ADC cases approved on or after October 1, 2009

When ADC cash assistance is paid to an individual or family unit, the State has the right to receive and keep child/spousal/medical support payments due to any persons listed in the application for assistance. This process, known as an assignment, includes support that becomes due while an individual is receiving ADC cash assistance. Support collections will be paid according to State and Federal laws and rules. Any child/spousal/medical support payments received directly by an ADC recipient in the same month as ADC cash assistance must be reported and returned to the State immediately.

Child Support Enforcement (CSE) Yearly Fee

The payee of the support order will be charged a $25.00 yearly fee once $500 of support has been disbursed, unless the payee meets one of the exemptions below. When a minimum of $500 has been disbursed, the next collection(s) will be retained by the Nebraska Department of Health and Human Services, and applied towards the $25.00 fee.

Exception to being charged the fee:

- Previously have or currently are receiving Aid to Dependent Children (ADC) and/or Temporary Assistance to Needy Families (TANF);
- CSE IV-D case(s) which include child(ren) who are currently and/or previously received IV-E foster care services; or
- Fee was assessed and collected in another state during current Federal Fiscal year.

I understand that it is my responsibility to notify the CSE office if my case qualifies as an exception as listed above.

Use of Social Security Number

Privacy Act of 1974 Notice; Disclosure of your social security number, and the social security numbers of your child(ren), is required by federal law 42 U.S.C. 666 (a) (13). Child Support Enforcement will use these social security numbers only for the purpose of establishing and enforcing support.

Nebraska Low Income Home Energy Assistance Program (LIHEAP)

In most instances, the LIHEAP payment will be sent to the utility providers. When a household receives LIHEAP, they must agree to take full responsibility for paying heating bills if the assistance payment comes directly to the household. If there is an overdue bill or poor payment history, the Nebraska Department of Health and Human Services (DHHS) is authorized and may make payment directly to the provider on behalf of the household.

Aid to Dependent Children (ADC) and Child Care Penalty Warning

Individuals who have knowingly provided false information in order to qualify for ADC or Child Care subsidy benefits may be subject to disqualification due to an Intentional Program Violation (IPV). For the ADC Program, only the individual found to have committed the IPV shall be disqualified. For the Child Care subsidy, the individual found to have committed the IPV and his/her family shall be disqualified. The period of disqualification shall be a) For a first violation, up to one year; b) For a second violation, up to two years; c) For a third violation, permanent disqualification. These penalties shall also be imposed if an individual is found by a court to have violated Neb. Rev. Stat. § 68-1017.

Supplemental Nutrition Assistance Program (SNAP) formerly known as Food Stamp Program (FSP) Penalty Warning

The information provided on this application is subject to verification by federal, state and local officials. If any is found inaccurate, participation in SNAP may be reduced, terminated or denied.

Individuals who have knowingly provided false information may be subject to criminal prosecution. Any member of a household who breaks any of these rules on purpose may be barred from SNAP for 12 months for the first violation, 24 months for the second violation, and permanently for the third violation. Additionally individuals may be fined up to $250,000, imprisoned for up to 20 years, and subject to prosecution under other applicable federal laws. A court can also bar an individual from the program for an additional 18 months.

DO NOT:

- **Give false, incorrect, or incomplete information to obtain or continue to obtain SNAP benefits.**
- **Trade or sell SNAP benefits or Electronic Benefits Transfer (EBT) cards.**
- **Use other people's SNAP benefits or EBT cards unless designated.**
- **Use SNAP benefits to buy nonfood items, such as alcohol, or cigarettes, or to pay on credit accounts.**
- **Use SNAP benefits to buy illegal drugs, firearms, ammunition, or explosives.**

Individuals found guilty in federal, state, or local court of the following offenses will be disqualified from participating in the Supplemental Nutrition Assistance Program (SNAP):

- **Use of SNAP benefits in the sale of a controlled substance, after September 22, 1996-disqualified for 24 months for the first violation, permanently for the second violation.**
- **Receipt of SNAP benefits in a transaction involving the sale of a controlled substance, after September 22, 1996-disqualified for 24 months for the first violation, permanently for the second violation.**
- **Drug felony for sale or distribution of a controlled substance including the intent to sell or distribute-permanently disqualified. An individual must have committed and had been convicted of the drug felony after September 22, 1996.**
- **Committed and been convicted of a drug felony for possession or use of a controlled substance or for a crime committed while under the influence of a controlled drug substance. If the individual has had three or more convictions for the possession or use, after August 22, 1996, the individual is permanently disqualified. If the individual has had fewer than three convictions and has not participated in or completed a state-licensed or nationally accredited substance abuse treatment program since the date of the last conviction, the individual is disqualified.**
- **Use of SNAP benefits to purchase firearms, ammunition, and explosives, after September 22, 1996--permanently disqualified.**
- **Receipt of SNAP benefits in a transaction involving the sale of firearms, ammunition, and explosives, after September 22, 1996-permanently disqualified.**
- **Misrepresenting residency or identity in order to receive multiple SNAP benefits--disqualified for 10 years.**
- **Trafficking of SNAP benefits of $500 or more, after September 22, 1996-permanently disqualified.**
- **During the time an individual is fleeing to avoid prosecution, custody or confinement after conviction for a crime or attempt to commit a crime that is a felony under the law of the place from which the individual is fleeing, or is violating a condition of federal or state probation or parole, the individual is ineligible to participate in SNAP.**

Child Care Subsidy Program

The purpose of the Child Care Subsidy Program is to assist low income families with child care. Care can be provided:

1. To children age **12 and younger**; it is available to youth age **13 through 18 only if a physician, licensed or certified psychologist, or licensed mental health practitioner has provided a written statement that the child has a special need**;

2. Only when there is a need for child care as defined in 392 NAC 3-008, which includes:

   a. **Employment** that has the potential to allow a family to become economically self-sufficient – this means we may not be able to continue to authorize child care if after a few months, the cost of child care is more than you earn. Child care is only authorized for those hours when the parent is actually working and reasonable travel time to and from work;

   b. **Actively Seeking Employment** – for families that are not Employment First clients, child care can only be authorized for two consecutive calendar months per program year (July 1 – June 30). No further child care can be authorized to look for work until that client has lost a job and is again seeking employment. The DHHS worker may ask the parent to provide a record of the dates and places that they looked for work;

   c. **Participation in an approved Employment First Activity** – Child care may be authorized for any approved EF activity. This means either the DHHS worker or the case manager from the EF contractor has approved the activity;

   d. **For a parent to obtain medical services** (such as doctor visits, Health Check, etc.) for themselves or another of their children or to visit their child in the hospital;

   e. **Enrollment in and regular attendance at vocational or educational training to attain a high school diploma or GED or an undergraduate degree or certificate** (including English as a second language classes) that will result in a parent becoming employed and self sufficient. Child care is not allowed for those pursuing a second undergraduate degree or any post-graduate degrees. Child care is not authorized for correspondence courses or independent study. For on-line classes, it can be authorized for one hour per week for each credit hour. Child care can be authorized for structured individual tutoring or group preparation time (such as GED preparation, ESL, and Adult Basic Education). Child care is not allowed for study time (unless it is a reasonable period of time between classes).

   f. **Participation in on the job training**;

   g. **Incapacitation as verified by a medical doctor** – a specific form will be given by DHHS to document need for child care due to incapacity; and

   h. **Needs which might be authorized by a Protection and Safety worker** as part of a plan with a family.

Important Information:

- **Child care authorization cannot begin before the date the parent reports a need for child care or a change to DHHS** Example: If you start care today or change your child care provider today and do not report it to DHHS for two weeks, child care will not be authorized for the two weeks before you contact DHHS
- **The parent is responsible to report the need for child care and any changes** – It is not the responsibility of the child care provider.
- For two parent households, **both parents must have one of the needs** for child care listed previously for child care to be authorized.
- Some families are required to pay a part of their child care expense. This is called a fee or obligation. **This fee must be paid** or the child care will be closed until the parent has made a satisfactory arrangement with the provider for payment of the fee.
- Child care in the child's home is called "In-Home Child Care" and can only be paid if the child has a special need (which must be documented by a medical doctor) OR a childhood illness OR if child care is needed during evening (after 6 PM or before 5AM), overnight, weekend, or holiday hours if there are no other available child care arrangements OR if there are three or more children in care. The In-Home provider may be an individual (other than the parent) who lives with the child only if the child has a special need or a childhood illness.

Let DHHS know if the non-custodial parent is court ordered or pays for any of the child care costs.

Child care can only be used for the purpose authorized. If you use child care for another purpose, you may be required to repay DHHS for the unauthorized child care.

- The parent who is requesting Child Care Subsidy must cooperate in establishing and collecting child support if there is a noncustodial parent. This applies only for a child who is receiving Child Care Subsidy. This requirement may be waived in the case of domestic violence.

Work Registration

For SNAP the signature of the head of household, other adult in the household, or an authorized representative on this application constitutes registering for work of all non-exempt household members.

When this application is signed I agree that

For purpose of complying with Neb. Rev. Stat 4-108 through 4-114, I hereby attest that my response and the information provided on this form and any related application for public benefits are true, complete and accurate and I understand that this information may be used to verify my lawful presence in the United States. This information may be verified by USCIS (formerly known as INS) through the submission of information from the application to USCIS, and that the submitted information received from USCIS may affect the household's eligibility and level of benefits. I understand my responsibilites and agree to fulfill them. I understand I may have to provide proof of what I have said. If written proof is not available, I agree to give the name or organization so that the Department of Health and Human Services may obtain the necessary proof. I will cooperate fully with state and federal personnel in a Quality Control Review.

I authorize the release of the Social Security Numbers provided on this application to Department of Health and Human Services to use for the purposes mentioned in the Rights and Responsibilties.

Authorization for Release of Information

I authorize the release of information requested by the DHHS. The requested information will be used solely in the administration of public assistance programs and will not be released to any other person or agency outside of the DHHS except I understand the DHHS may release information to another agency when services of that agency have been requested or when the objective in obtaining the information is to provide services to me or to any member of the assistance unit.

Receipt of Information Packet

I acknowledge that I received the packet of information that includes my Rights and Responsibilities, Reporting Changes, Fair Hearings, Work Requirements, Medicaid, and the HIPAA Notice.

INITIAL HERE ✍ _____(Initial)

A reproduction of this release is as valid as the original

_____ _____

Signature of Applicant Date

Signature of Other Adult Household Member Date

_____

Printed Name (if applicant signs with a mark) Date

_____ _____

Signature of Witness (if a mark was used) Date

Signature of Person Who Helped Date
(Authorized Representative/Conservator/Guardian/
Power of Attorney/Interpreter/Translator)

INFORMATION PACKET

YOU HAVE THE RIGHT TO:

- Apply and discuss any action taken on your application or case with a worker or a supervisor.
- Be assisted in the application process by the person of your choice.
- Referral to other private or public agencies.
- See a copy of the program regulations.
- Have an interview in your home, at a mutually agreed upon location, or by telephone.
- Reasonably prompt action on your application for benefits.
- Adequate notice of any action affecting your application or case.
- Have program requirements and benefits fully explained.
- Receive medical assistance (Medicaid) without a separate application if you are eligible for Aid to Dependent Children (ADC) or Aid to the Aged Blind and Disabled (AABD).
- Have your information treated confidentially.

YOU HAVE THE RESPONSIBILITY TO:

- Provide complete and accurate information. You may be subject to criminal penalties under applicable state or federal laws if you do not provide complete and accurate information. You are primarily responsible for providing proof of your household situation, but a worker will assist you in obtaining verification if you cooperate with the application process.
- Apply for and accept any potential benefits or income you may be eligible for if requested to do so by a worker.
- Pay a co-pay for certain medical services if required to do so.
- Pay a fee to your child care provider if required to do so based on your income.
- Cooperate with state and federal personnel in a Quality Control review.
- Cooperate with Nebraska Managed Care Program for certain Medicaid recipients.
- Cooperate with Nebraska Child Support Enforcement.
- Ask questions if you do not understand something about any program requirements.

FAIR HEARINGS

If you disagree with any action taken by the Nebraska Department of Health and Human Services (DHHS) which affects your benefits, you may request a fair hearing in writing. Fair hearing for SNAP can be requested verbally by contacting DHHS. You may continue to receive your current level of assistance until a hearing decision is made IF (1) you request a hearing within ten days from the date of the agency notice, and (2) for SNAP benefits only, your certification period has not expired. A fair hearing request must be made within 90 days of the action or inaction. You or your representative have the right to examine your case record. At the hearing you may represent yourself or be represented by another person.

CIVIL RIGHTS

In accordance with Federal law and U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. Under the Food Stamp Act and USDA policy, discrimination is prohibited also on the basis of religion or political beliefs.

To file a complaint of discrimination, contact USDA or HHS. Write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, S.W., Washington D.C. 20250-9410 or call (800) 795-3272 (voice) or (202) 720-6382 (TTY). Write HHS Director, Office for Civil Rights, Room 506-F, 200 Independence Avenue, S.W., Washington D.C. 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TTY). USDA and HHS are equal opportunity providers and employers.

VOTER REGISTRATION

Please note that the information and office to which application was made will remain confidential and be used only for voter registration purposes. Applying to register or declining to register to vote will not affect the amount of assistance or services that you will be provided by this agency. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the:

Nebraska Secretary of State
State Capitol Building
Lincoln, Nebraska 68509-4608
Telephone: (402) 471-2554

REPORTING CHANGES FOR AABD, ADC, AND MEDICAID

(This includes Kids Connection and Children's Medical)

Report all changes within ten days to DHHS such as:

- Changes in the household, someone moves in or out
- If you move
- New employment
- Termination or change of employment - including job training or other work activities
- Change in the amount of monthly income
- Changes in disability or incapacity
- A change in health insurance
- A change in a resource (not required for Kids Connection or Children's Medical)

You may report these changes online: www.ACCESSNebraska.ne.gov. Click on "Report Changes".

REPORTING CHANGES FOR SUPPLEMENTAL NUTRITION ASSISTANACE (SNAP) BENEFITS FORMERLY KNOWN AS FOOD STAMP PROGRAM

There are three reporting categories in SNAP: Change Reporting (CR), Simplified Reporting (SR), and Transitional Benefits Reporting (TBR). The reporting category to which you will be assigned is determined by your household situation. You will be informed of the reporting category, certification period and reporting requirements on your Notice of Eligibility. You will receive the Notice of Eligibility by mail. If your SNAP benefit reporting category changes during the certification period, you will receive another notice with the new reporting requirements for the new category. If you have any questions, or need help in understanding your notice or reporting category, contact DHHS or go online at ACCESSNebraska.ne.gov and select "Report Changes".

ELECTRONIC BENEFITS TRANSFER (EBT) CARD

SNAP benefits are issued on an Electronic Benefits Transfer (EBT) card. If you have lost or misplaced your EBT card, please call 1-877-247-6328 to request a replacement card.

SOCIAL SECURITY NUMBER

The DHHS asks for Social Security Numbers (SSNs) of all individuals for whom assistance/benefits is requested as required by the federal Social Security, Food Stamp Acts and under the Food and Nutrition Act of 2008, as amended, 7 U.S.C.2011-2036. Individuals who are not applying for assistance for themselves are not required to have or provide a SSN. If the individual is financially responsible for others in the assistance unit, the SSN will be used only to verify income and/or resources through computer matches as listed below or other contacts so that eligibility can be determined for those requesting assistance. If the SSN is not provided, the assistance unit must assume responsibility for providing the information needed to determine eligibility for the individuals requesting assistance. Any SSNs provided will be used and disclosed in the same manner as SSNs of eligible participants. For SNAP benefits, SSNs may be disclosed to other federal and state agencies for official examination and to law enforcement officials for the purpose of apprehending persons fleeing to avoid the law. If a household has a SNAP benefit overpayment, the information on this application, including the SSNs, may be referred to federal and state agencies as well as private collection agencies for overpayment collection action.

The SSN of each person in the assistance unit who is applying for assistance and provides her/her SSN will be computer matched with the following agencies to assist in the determination of eligibility: Income and Eligibility Verification System, Nebraska Department of Health and Human Services, Nebraska Department of Labor, Social Security Administration, Clerk of the District Court, Child Support Payment Center, Internal Revenue Service, and Veterans' Administration.

The information received from these agencies is used and verified when discrepancies are found by DHHS; this information may affect the household's eligibility and level of benefits. SSNs are also used in computer matching and program reviews or audits to make sure each household gets the correct amount of benefits. This may result in criminal or civil action or administrative claims against persons fraudulently participating.This information will also be used to monitor compliance with program requirements and for program management.

Child Care Assistance, Social Services for the Aged and Disabled (SSAD) and Social Services for Children and Families (SSCF): An SSN is not required to apply for these programs and eligibility will not be denied if SSNs are not provided. If an SSN is provided, it will be used to assemble research data sets that do not identify individuals and to verify income.

If you are applying for SNAP benefits, Medicaid, or Child Care Assistance, this application asks you to tell us about the citizenship and immigration status of people in your household. For Medicaid, Kids Connection, Child Care Assistance, you must tell us about the citizenship or immigration status for the children who will receive assistance. If anyone in your household doesn't have a SSN, we can help them apply for one and your application will not be delayed.

Only those people who provide information regarding their immigration status and SSNs can receive SNAP benefits and/or Medicaid. If some family or household members do not wish to apply for SNAP benefits or Medicaid, they do not need to provide this information. If people in your household choose not to give us information about their immigration status or SSN, they must still provide us the information needed to determine the eligibility of the other persons in your household. You may withdraw your request for benefits for these persons or you may withdraw your entire application.

MEDICAID

Third Party Liability: Individuals who receive Medical Assistance (Medicaid) assign to the Department of Health and Human Services (DHHS) their right to any medical support or other payment for medical care, agree to cooperate with the DHHS in establishing paternity, and cooperate with the DHHS in obtaining any available third party such as an insurance payment or court settlement. Medicare benefits are not assigned. Individuals must cooperate with the DHHS in obtaining reimbursement for the cost of medical care and services for any members of the assistance unit. Refusal to cooperate will result in the termination of medical assistance eligibility for that individual. The DHHS will waive the requirement to cooperate if it determines that the individual has good cause for refusing to cooperate. If at any time you want to claim good cause, you must tell DHHS that you think you have good cause. Good cause is a finding by the DHHS that cooperation is against the best interests of the child or against the best interests of the individual because it is anticipated that cooperation will result in reprisal against, and cause physical or emotional harm, to the individual or other person. Nebraska Revised Statutes § 68-716, 68-916, and 68-917.

Medical Records Release: Upon request, any person who has medical records and information or the custody of such records regarding Medicaid recipients must release them to the DHHS. This information will be used as provided in the Notice of Information Privacy Practices.

Medical Reimbursement Agreement: When the DHHS pays for services for a Medicaid recipient, the amount the DHHS has paid to treat the injury or illness must be included in any legal claim made against a third party. If the Medicaid recipient later receives an insurance or court settlement, the DHHS must be notified of the settlement and repaid from the settlement for the medical assistance the DHHS has previously paid.

Medicaid:

- Present proof of your current Medicaid eligibility to medical providers before obtaining services.
- Ask your medical provider or DHHS about which services are covered.
- Inform DHHS and your medical providers of any health insurance coverage you have (including dental coverage.)
- Agree to enroll in employer-based group health insurance if the DHHS determines it is cost effective.
- Agree to comply with managed care requirements.
- Pay the cost of all non-covered medical expenses.
- If you get any bills or statements from providers or collection agencies, you are responsible to tell them right away your coverage is Nebraska Medicaid.

Failure to follow certain conditions may result in your being responsible to pay the bills.

Annuity Requirement As a condition of receiving medical assistance coverage for long term care services for you or your spouse, the DHHS must become the remainder beneficiary of any annuity under standards prescribed by the U.S. Secretary of Health and Human Services.

Medicaid Estate Recovery Program: Under Federal law (Social Security Act, Title 19, Sec. 1917 {42 U.S.C. 1396P}) and State law (Nebraska Rev. Stat. 68-919), the Medicaid Estate Recovery Program authorizes the DHHS to make recovery from the estates of deceased Medicaid clients who were permanently institutionalized or were over the age of 55 when benefits were provided. The Federal and State laws provide for certain exemptions to the Medical Assistance Estate Recovery Program (471 NAC 38-000). For further information or questions about the Medicaid Estate Recovery Programs, you should contact DHHS and request the “Medicaid Estate Recovery” program brochure.

WORK REQUIREMENTS

Aid to Dependent Children (ADC)/Employment First (EF) Work Requirements If you receive ADC cash assistance, you must participate in approved work activities unless you qualify for an exemption. If you do not cooperate with the work requirements, your benefits may be reduced or ended. ADC recipients will be required to develop and sign an individualized Self-Sufficiency Contract that will identify the goals and list the steps necessary to become economically self-sufficient.

VOICE RESPONSE UNIT (VRU) 1-800-383-4278
or in Lincoln 402-323-7455

A VRU is an automated answering service that will provide you with information regarding your application and/or benefits. This service is available to you 24 hours a day, 7 days per week accessed by the above toll free number. The information on the VRU is available in English and Spanish.

Department of Health & Human Services
DHHS
NEBRASKA

Notice of Information Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you may access this information. Please review it carefully. *Effective:04/14/2003*

The Department of Health and Human Services of the State of Nebraska, and those Agencies inclusive of health care facilities and medical assistance programs that are affiliated under the common control of the Nebraska Partnership for Health and Human Services Act, are required by federal law to maintain the privacy of Protected Health Information and to provide notice of its legal duties and privacy practices with respect to Protected Health Information.

PRACTICES AND USES:

DHHS may access, use and share medical information for purposes of :

- **Treatment:** We may use your medical information to provide you with medical treatment or services. For Example; a doctor may need to tell the dietitian if you have diabetes so that appropriate meals can be prepared.
- **Payment:** We may use and disclose your medical information so that the treatment and services you receive can be billed. For example, we may use your medical information from a surgery you received at the hospital so that the hospital can be reimbursed.
- **Operations:** We may use and disclose medical information about you for medical operations. For example, we may use medical information to review your treatment and services and to evaluate the performance of the staff.

OTHER PERMITTED USES AND DISCLOSURES THAT MAY BE MADE WITHOUT CONSENT:

- **Required By Law:** We may use or disclose your Protected Health Information to the extent that the use or disclosure is required by law. You will be notified, if required by law, of any such uses or disclosures.
- **Public Health:** We may disclose your Protected Health Information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information.
- **Communicable Diseases:** We may disclose your Protected Health Information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.
- **Health Oversight:** We may disclose Protected Health Information to a health oversight agency for activities authorized by law, or other activities necessary for appropriate oversight of the health care system, government benefit programs, other government regulatory programs, and civil rights laws.
- **Abuse or Neglect:** We may disclose your Protected Health Information to a public health authority that is authorized by law to receive reports of abuse or neglect. The disclosure will be made consistent with the requirements of applicable federal and state laws.
- **Legal Proceedings:** We may disclose Protected Health Information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), and in certain conditions in response to a subpoena, discovery request, or other lawful process.
- **Law Enforcement:** We may also disclose Protected Health Information, so long as applicable legal requirements are met, for law enforcement purposes.
- **Food and Drug Administration:** We may disclose your Protected Health Information to a person or company as required by the Food and Drug Administration.
- **Coroners, Funeral Directors, and Organ Donation:** We may disclose Protected Health Information to a coroner or medical examiner for identification purposes, cause of death determinations, or for the coroner or medical examiner to perform other duties authorized by law.
- **Research:** We may disclose your Protected Health Information to researchers when their research has been approved by an institutional review board to ensure the privacy of your Protected Health Information.
- **Criminal Activity:** Consistent with applicable federal and state laws, we may disclose your Protected Health Information if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
- **Military Activity and National Security:** When the appropriate conditions apply, we may use or disclose Protected Health Information of individuals who are Armed Forces personnel.
- **Workers' Compensation:** We may disclose your Protected Health Information as authorized to comply with workers' compensation laws and other similar legally established programs.
- **Inmates:** We may use or disclose your Protected Health Information if you are an inmate of a correctional facility in the course of providing care to you.
- **Required Uses and Disclosures:** Under the law, we must make disclosures when required by the Secretary of the U.S. Department of Health and Human Services to investigate or determine our compliance with the requirements of 45 CFR, Title II, Section 164, et. seq.

OTHER USES OF MEDICAL INFORMATION

You can provide us written authorization to use your medical information for other purposes, you may revoke that permission, in writing, at any time.

THIS NOTICE IS AVAILABLE IN LARGER PRINT AND WITH DETAILED EXPLANATION UPON REQUEST.

Department of Health & Human Services
DHHS
NEBRASKA

DHHS, HIPAA Privacy and Security Office, 301 Centennial Mall South, 3rd Floor, P.O. Box 95026, Lincoln, NE 68509-5026

YOUR RIGHTS TO PRIVACY:

❖ **Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records but does not include psychotherapy notes. To inspect and copy your medical information, you must submit your request in writing at the Site of Service, or to the State of Nebraska, Department of Health and Human Services, HIPAA Privacy and Security Office at the address on the top of this Notice. If you request a copy of information, we may charge a fee for the cost of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request the denial be reviewed. For more information call **(402) 471-8417.**

❖ **Right to Amend.** If you feel that medical information about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by or for DHHS. To request an Amendment, your request must be made in writing and submitted at the Site of Service, or to the State of Nebraska, Department of Health and Human Services, HIPAA Privacy and Security Office**.** In addition you must provide a reason which supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for DHHS;
- Is not part of the information which you would be permitted to inspect and copy; or,
- Is accurate and complete.

❖ **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list, you must submit your request in writing at the Site of Service, or to the State of Nebraska, Department of Health and Human Services, HIPAA Privacy and Security Office address on the top of this Notice. Your request must state a time period for the disclosures, which may not be longer than six (6) years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list to be provided to you: for example, on paper, or by e-mail..

❖ **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you can ask that we not use or disclose information about a surgery you had performed.

❖ **We are not required to agree to your request for restrictions.** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing at the Site of Service, or to the State of Nebraska, Department of Health and Human Services, HIPAA Privacy and Security Office at the address on the top of this Notice. In your request you must tell us: (1) what information you want to limit, (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply; for example, disclosures to your spouse.

❖ **Right to Request Confidential Communications**. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing at the Site of Service, or to the State of Nebraska, Department of Health and Human Services, HIPAA Privacy and Security Office. Your request must specify how or where you wish to be contacted.

How to file a complaint about your privacy rights

If you believe your privacy rights have been violated, you may file a complaint with **DHHS** or with the **Secretary of the U.S. Department of Health and Human Services**. To file a complaint with DHHS, you may contact our Privacy Contact, **DHHS HIPAA Privacy and Security Office** at **(402) 471-8417** Monday through Friday from 9:00 a.m. to 4:30 p.m., except State holidays, or dhhs.HIPAAOffice@nebraska.gov for further information about the complaint process. To file a complaint with HHS, contact: **Secretary, Health and Human Services, Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 1-866-OCR-PRIV (627-7748). You will not be penalized for filing a complaint.**

Changes to the Notice of Information Practices

The State of Nebraska Department of Health and Human Services reserves the right to amend this Notice at any time in the future. Until such amendment is made, DHHS is required by law to abide by the terms of this Notice. DHHS will provide notice of any material change in revision of these policies.

Contact Information

This notice fulfills the "Notice" requirements of the Health Information Portability and Accountability Act of 1996 (HIPAA) Final Privacy Rule. If you have questions about any part of this Notice of Information Privacy practices or desire to have further information concerning information practices at the State of Nebraska, Department of Health and Human Services please direct them to: The HIPAA Privacy and Security Office, 301 Centennial Mall South, Lincoln, Nebraska 68509-5026. By e-mail to dhhs.HIPAAOffice@nebraska.gov .

THIS NOTICE IS AVAILABLE IN LARGER PRINT AND WITH DETAILED EXPLANATION UPON REQUEST.