NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Nebraska Department of Health and Human Services
Disabled Persons and Family Support Program

Disability Report

I am applying for assistance through the Disabled Persons and Family Support Program which is administered by the Nebraska Department of Health and Human Services. This medical report is required to verify I have a medically determinable severe, chronic disability and need some form of support to prevent out-of-home placement or return to independent living.

Section I:
To Be Completed By The Applicant/Patient Or Applicant's Representative
(Before Submitting To A Licensed Health Care or Medical Professional)

Name of Licensed Health Care or Medical Professional

Mailing Address	Phone Number	Email
City		Zip Code
Applicant's Name	Phone Number	Birthdate
Mailing Address		Email
City		Zip Code
Name of Representative for the Applicant/Relationship (if applicable)		☐ Legal Guardian ☐ Other ☐ DPOA ☐ POA

Mailing Address

City	Zip Code
Email	Representative's Phone Number

Describe personal care needs requiring assistance to remain in an independent living situation.

My application for this Program will not be complete until this report is received.

☐ I will submit it to the Program
☐ If you prefer, you have my consent to send it to:

Disabled Persons & Family Support Program
P.O. Box 98933
Lincoln, NE 68509-8933
dhhs.DPFS@nebraska.gov
Fax: (402) 742-8396

If there is a charge for completion of this report, bill me privately.

Applicant/Representative Signature	Date

The Reverse Side Of This Form Must Be Completed By Licensed Health Care or Medical Professional

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SECTION II:
Physician, Physician Assistant, Licensed Nurse or Other Health Care Professional

Disability: Disability for this Program is a medically determinable, severe, chronic condition which:

1. Is attributable to mental and/or physical impairments;
2. Is likely to continue indefinitely;
3. Demonstrates a need for long-term, individually planned and coordinated care, treatment, vocational rehabilitation, or other services; and
4. Results in substantial functional limitations in two or more of the following areas of major life activity -
   a. Self-care (also referred to as personal care);
   b. Receptive and expressive language;
   c. Learning;
   d. Mobility;
   e. Self-direction;
   f. Capacity for independent living;
   g. Work skills or work tolerance; and
   h. Economic sufficiency.

In your opinion, does this applicant meet the disability requirements given above, AND, is the disability likely to continue indefinitely?

☐ **NO**, this person does not meet the above definition of disability for the following reason(s):

☐ **YES,** this person does meet the above definition of disability.

This disability causes substantial functional limitations in the following (areas):

☐ Frequent Memory/Cognitive Issues
☐ Bathing
☐ Grooming/Hygiene
☐ Dressing
☐ Toilet Use
☐ Mobility/Fall Risk
☐ Transferring/Positioning
☐ Medication Management
☐ Fall History
☐ Learning
☐ Receptive & Expressive Language
☐ Self-direction
☐ Work Skills

Check item(s) affecting ability to eat:
☐ Food Preparation
☐ Choking
☐ Swallowing
☐ Taste
☐ Nausea/Vomiting
☐ Cutting Up Food
☐ Vision
☐ Opening Containers
☐ Dentures (lack of/poor fit
☐ None

Please give a brief statement INCLUDING DIAGNOSIS. Add any comments to verify assistance needed with applicant's personal care need(s) to remain in an independent living situation:

How long have you known applicant?

Signature of Health Care or Medical Professional	Date