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

Nebraska Department of Health and Human Services

Medically Handicapped Children's Program Application

Do you need an interpreter? ☐ Yes ☐ No If yes, what language do you speak?

Name of Applicant	Date of Birth	Gender ☐ Male ☐ Female	Social Security Number

Applicant Citizenship Status: ☐ A Citizen of the United States OR ☐ I am a qualified alien under the federal immigration and Nationality Act
Immigration Status and Alien Number:

Parent/Guardian Name		Email Address (Elect to receive email correspondence) ☐ Yes ☐ No		
Address		Mailing Address (if different)		
City		State	Zip	County
Home Phone	Cell Phone		Work Phone	
School/Grade		Primary Care Physician		
Health Insurance		Physician Specialists		

Household Members	Date of Birth	Gender	Relationship to Applicant

(Please use additional sheet, if needed)

Please describe your child's medical condition(s):

Insurance Company	Monthly Premium Amount	Policy Number or Group Plan Number	Type of Coverage (medical, dental, vision, prescription)	Who is covered by Policy?

Financial Information: List the amount of income you receive (your family) from each of these sources below. Applicants 19 years of age or older should list only YOUR income.

Gross Income (income before deductions)	Amount	How often received?	Who receives it?	Employer
Wages, overtime, bonuses, commission, etc. (Paystubs may be required for verification)				
Self-Employment (Complete copy of Federal IRS 1040 is required)				

Gross Income (income before deductions)	Amount	How often received?	Who receives it?
Alimony			
Child Support			
Unemployment Compensation			
Workman's Compensation			
Interest (on savings or bonds)			
Dividends (from stockholdings, Or association memberships)			
Retirement Pensions			
Inheritance, Estates, Trust Funds, etc.			
Supplemental Security Income (SSI)			
Veteran's Pensions			
Contributions (family support)			
Rental Income			
Net Land Lease Income			
Boarders			
Royalties			
Social Security Retirement			
Maintenance of State or County Ward (including foster care payments)			

Expenses:	
Child Care Costs for Employment (per month)	Child Support/Alimony Paid (per month):
Tuition/Books Paid Out-of-Pocket for 1st Degree (last 12 months)	

Is anyone in the household **currently** active or reserve in any branch of the United States military? ☐ Yes ☐ No

Has anyone in the household **previously** served in any branch of the military? ☐ Yes ☐ No

(If yes to either question, please provide additional information below.)

Name of Individual	Please check all that apply:
	☐ Veteran ☐ Spouse of Veteran ☐ Active ☐ Reserve ☐ Currently receives VA benefits
	☐ Veteran ☐ Spouse of Veteran ☐ Active ☐ Reserve ☐ Currently receives VA benefits
	☐ Veteran ☐ Spouse of Veteran ☐ Active ☐ Reserve ☐ Currently receives VA benefits

Demographics (Optional):

Ethnicity:
- ☐ Not of Hispanic, Latino, or Spanish origin
- ☐ Mexican
- ☐ Puerto Rican
- ☐ Central American
- ☐ Cuban
- ☐ South American
- ☐ Other Hispanic, Latino, or Spanish origin
- ☐ Other/Unknown

Race:
- ☐ Black/African American
- ☐ White/Caucasian
- ☐ Asian
- ☐ American Indian
- ☐ Alaskan Native
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ Other/Unknown

I AGREE TO:

1. Notify the Medically Handicapped Children's Program worker before receiving services at scheduled appointments and laboratory tests;
2. Keep all appointments for medical care and medical examinations;
3. Follow the individual medical treatment plan;
4. Notify the Medically Handicapped Children's Program worker of emergency care within five working days;
5. Obligate payment for that part of the treatment which has been agreed upon by the Medically Handicapped Children's Program and the client or has been determined to be the client's responsibility;
6. Assume responsibility for general health care for the client; and
7. Allow the Department of Health and Human Services to release and obtain any medical information for the purpose of medical treatment.

I have answered all questions on this form truthfully. I understand that providing false information may be subject to criminal penalties under state and federal laws.

Signature of Parent/Legal Guardian, Representative, or Applicant (if over the age of 19 years old)	Signature Date

Submit applications using one of the following methods:
Email: DHHS.MHCP@nebraska.gov
Fax: (402) 328-6219
Mail: Medically Handicapped Children's Program, PO Box 95026, Lincoln, NE, 68509-5026

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Medically Handicapped Children's Program

Rights and Responsibilities

PLEASE KEEP THIS FOR YOUR INFORMATION

When completing an application for the Medically Handicapped Children's Program, Disabled Children's Program, or Genetically Handicapped Persons Program:

YOU HAVE THE RIGHT TO:

- Apply and discuss any action taken on your application or case with a worker or supervisor.
- Be assisted in the application process by the person of your choice.
- Expect reasonably prompt action on your application for benefits.
- Receive adequate notice of any action affecting your application or case.
- Have program requirements and benefits fully explained to you.
- Be referred to other private or public agencies.
- See a copy of the program regulations.

YOU HAVE THE RESPONSIBILITY TO:

- Provide complete and accurate information. Providing false information may be subject to criminal penalties under applicable state and federal laws.
- Complete and submit required information prior to eligibility determination at the time of application, annually, or as requested. This may include a copy of your tax returns or other verification of income.
- Apply for and accept any potential benefits you may be eligible to receive.
- Ask questions if you do not understand something about program eligibility.

RIGHT TO APPEAL

You have the right to appeal any action or inaction of any state employee or official with regard to application for or receipt of services. You may appeal because your application for services is denied, is not acted upon with reasonable promptness, or if your services are suspended, reduced, discontinued or terminated.

You (or your representative) have 90 days following the date the notice of action is mailed to request a fair hearing.

In cases of adverse action, DHHS is required to send you adequate and timely notice. If you request an appeal hearing within ten days following the date the notice of action is mailed, DHHS shall not carry out the adverse action until a fair hearing decision is rendered. This regulation does not apply to those situations where only adequate (not timely) notice is required.

This regulation in no way restricts DHHS from continuing normal case activities and implementing changes to your case that are not directly related to the appeal issue.

To file an appeal you may contact the assigned worker. DHHS will explain the appeal procedure and assist you in completing the appeal form. The appeal request must be in writing.

Once you've filed the appeal, arrangements for a hearing will be made and you will be notified of the time and place. You may represent yourself at the hearing or be represented by a legal representative of your choosing.

RIGHT TO BE FREE FROM ABUSE, NEGLECT, OR EXPLOITATION

You have the right to be free from situations which may endanger your life, physical health, or mental health. If you believe you are being abused, neglected or exploited, report your concerns to the proper authorities. This may include the Nebraska Hotline for reporting abuse and neglect: 1-800-652-1999.

RESPONSIBILITY TO REPORT

You must tell your worker within 10 days if:

- You move to a new residence.
- Someone moves in with you.
- Someone leaves your household.
- Your monthly income changes.