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

Division of Children and Family Services

Application for Economic Assistance Benefits

*The **first two pages** are **only to provide information** to help you complete the Application for Economic Assistance Benefits. This is **not part of the application**. Nothing marked on the cover page will be considered as part of your application.*
***Please note** this is not an application for **Medicaid** coverage or services.*
*Please contact 1-855-632-7633 if you wish to apply for **Medicaid**.*

Applicants and prospective applicants that indicate that they may have difficulty completing the application process, that a non-household member may be designated as the authorized representative for application processing purposes. The household member or the authorized representative may complete work registration forms for those household members required to register for work. The authorized representative designated for application processing purposes may also carry out household responsibilities during the certification period, such as reporting changes in the household's income or other household circumstances. Except for those situations in which a drug and alcohol treatment center or other group living arrangement acts as the authorized representative, the household that the household will be held liable for any overissuance that results from erroneous information given by the authorized representative.

PROGRAMS AVAILABLE - *Information ONLY. Do not select programs on this page.*	
FOOD AND ENERGY ASSISTANCE PROGRAMS	
Supplemental Nutrition Assistance Program helps low-income households buy food. Formerly known as Food Stamps. • *Questions noted with an* 🍎 *are applicable to SNAP but are not required to submit the application.*	**SNAP**
Low-Income Home Energy Assistance Program helps households pay for heating, cooling, deposits, repairs and eligible crisis/ disconnect situations. • *If applying for LIHEAP, everyone who lives at your address is required to apply.*	**LIHEAP**
REFUGEE ASSISTANCE PROGRAMS	
Refugee Resettlement Program helps eligible individuals who have moved to the United States within the past ***twelve (12) months*** with cash, medical and non-cash benefits.	**RRP**
FAMILY AND CHILDREN PROGRAMS	
Aid to Dependent Children provides financial assistance (or cash payment) to help support children 18 and younger who live in the household. Participation in Employment First, a work readiness program, may be required.	**ADC**
Child Care Subsidy helps pay for child care services.	**CC**
Social Services Children and Family helps pay for non-medical transportation and independent skills.	**SSCF**
Emergency Assistance provides financial assistance or other services to households with children that lack food, shelter and/or medical care due to an emergency situation.	**EA**
AGED, BLIND AND DISABLED PROGRAMS	
Assistance to the Aged, Blind and Disabled provides cash payment or financial assistance to individuals who are receiving SSI through Social Security Administration (SSA), age 65 or older, blind, or disabled. • *Special requirements: Essential items for one's health and welfare which are not included in the basic standard or covered by Medicare, Medicaid, or any other resources, personal or public.*	**AABD**
State Disability Program provides cash payment or financial assistance to individuals under age 65 who have been denied by the Social Security Administration for "lack of duration" and determined temporarily disabled for at least 6 months but not more than 12 months. Individuals cannot be eligible for Medicaid and SDP at the same time.	**SDP**
Social Services for the Aged and/or Disabled helps aged or disabled individuals pay for needed services to remain in their home independently. • Chore: services to help individuals live more independently. • Transportation: medical and non-medical transportation. • Meals: home-delivered and congregate. • Adult Day Care: social activities in a licensed setting.	**SSAD**
Personal Assistance Services provides assistance with activities of daily living, such as bathing or dressing, for an individual who has a chronic medical condition or a disability so they may remain in their home independently.	**PAS**

Email:	DHHS.ANDICenter@nebraska.gov	**Calling From Lincoln:**	(402) 323-3900
Fax:	(402) 742-2351	**Visit a Local Office:**	(402) 595-1258
Mail:	DHHS ANDI Center Economic Assistance P.O. Box 2992 Omaha, NE 68103-2992	**TTDD:**	(402) 471-7256
		Call Toll-Free:	1-800-383-4278
		Visit a Local Office:	Find the closest local office at: **https://dhhs.ne.gov/Pages/Public-Assistance-Offices.aspx**

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PROCESS FOR APPLYING FOR ECONOMIC ASSISTANCE BENEFITS

APPLICATION

Complete application:

- Online
- Paper form
- By Phone
- In person at your local office

SUBMIT

- Online
- Email
- Fax
- Mail
- At your local office
- Information listed previous page.

INTERVIEW

If required:

- DHHS will call for an interview
- Additional documents that may be requested are listed below.

DECISION

- DHHS will provide you with a written notice with eligibility determination

TO SUBMIT FASTER, COMPLETE ONLINE APPLICATION AT WWW.ACCESSNEBRASKA.NE.GOV OR CALL TO COMPLETE AN APPLICATION OVER THE PHONE

Days to Process for SNAP: Those eligible for expedited service will receive SNAP benefits within 7 days from when DHHS received the application. Those not eligible for expedited service may receive SNAP benefits within 30 days from when DHHS received the application. Benefits will be determined from the date the application is received by DHHS.

ADDITIONAL DOCUMENTS

When you see the paperclip symbol, it means that you may be required to send in proof of the items listed in that section. You will be contacted regarding what is specifically required, or you can attach copies of verification with the application. DHHS is required to assist you in obtaining requested verifications. Contact DHHS if you are unable to obtain requested verification.

These may include proof of identity, income, expenses, resources, etc. Examples of documents are listed below. Originals will not be returned.

- ✓ Verification of Identity (State issued photo ID, Social Security Card, Birth certificate, or Permanent Resident ID Card)
- ✓ Verification of Pregnancy (Doctor's note)
- ✓ Verification of Disability (Doctor's note, SSI papers)
- ✓ Verification of Alien Information (copy of the front and back of your US citizenship and Immigration Services card)
- ✓ Verification of Closed Benefits from other States
- ✓ Verification of Income for the Past 30 Days
- ✓ Verification of Utility Bills
- ✓ Verification of Shelter Costs (Rent, mortgage, lot rent, property taxes, property insurance)
- ✓ Verification of Life Insurance Policies
- ✓ Verification of Bank Statements

Email: DHHS.ANDICenter@nebraska.gov. **Mail:** PO Box 2992 / Omaha, NE 68103-2992.
Call: 1.800.383.4278. In Lincoln: 402.323.3900. **In Omaha:** 402.595.1258. **Fax:** 402.742.2351

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You or your Authorized Representative may submit an application with only your name, address, and signature on this page.

Programs Needed	Food & Energy		Refugee	Family & Children				Aged & Disabled			
Which programs do you want to apply for?	SNAP ☐	LIHEAP ☐	RRP ☐	ADC ☐	CC ☐	EA ☐	SSCF ☐	AABD ☐	PAS ☐	SSAD ☐	SDP ☐

Please note this is not an application for **Medicaid** coverage or services. Contact 1-855-632-7633 to apply for **Medicaid**

Cards Needed		
Do you have a Nebraska Electronic Benefits Transfer (EBT) card for Supplemental Nutrition Assistance Program (SNAP) Benefits?	☐ Yes	☐ No, I will need an EBT card.
Do you have a Nebraska US Bank ReliaCard for LIHEAP, RRP, ADC, and/or AABD?	☐ Yes	☐ No, I will need a ReliaCard.

APPLICANT INFORMATION/HEAD OF HOUSEHOLD: If your household has more than one adult, you must tell ACCESSNebraska which adult should be designated as "Head of Household." **DHHS WILL USE THE PERSON LISTED HERE AS THE HEAD OF HOUSEHOLD.**

First Name:	MI	Last Name:	Social Security Number:	Date of Birth:

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

Where do you live?
☐ House – rent/own/mortgage ☐ Apartment/Duplex/Triplex ☐ Rent a Room ☐ Homeless
☐ Room and Board ☐ Treatment Center ☐ Assisted Living ☐ Shelter
☐ Nursing Home ☐ Group home/Foster Care/Child Care Institution/Adult Family home
☐ Center for Developmentally Disabled ☐ Other: _____

Facility or shelter name (if applies): | **Is this public/subsidized housing?** ☐ Yes ☐ No

Is anyone in the household a boarder? ☐ Yes ☐ No | **Is the applicant a boarder?** ☐ Yes ☐ No

Boarder: *An individual who either lives in a commercial boarding house or lives with a household and pays reasonable compensation in cash for meals and lodging. A boarder is not considered a member of a participating household and his/her income and resources are not considered available to the household.*

Physical Address (Street, Apt/Unit #):	City:	State:	Zip:
Mailing Address if Different (Street, PO Box, Apt/Unit #):	**City:**	**State:**	**Zip:**

Do you have someone who needs to be listed as the "In Care Of" (c/o)? ☐ Yes ☐ No | **If so, who:**

Do you need to have your mail sent to general delivery? ☐ Yes ☐ No | **If so, please provide the City/State or ZIP:**

Prior Address (Street, Apt/Unit #):	City:	State:	Zip:

If you are not registered to vote where you live now, would you like to apply to register to vote today? ☐ Yes ☐ No

IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME. Any citizen in the State of Nebraska who has met the voter registration requirements and applies for economic assistance 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. Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency. Please note that the information and office to which application was made will remain confidential and be used only for voter registration purposes. If you believe 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, PO BOX 94608, Lincoln NE 68509-4608, 402-471-2555.

I state under penalty of perjury that I completed the application to the best of my knowledge and my answers are true and correct including information concerning citizenship and alien status of the members applying for benefits. I authorize the release of information to DHHS. The requested information will be used only in administration of economic assistance programs and will not be released to any other person or agency outside of DHHS. I understand 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 my household. I read, understand and agree to the "What Should I Know" section located on the last pages of this document.

Applicant or Authorized Representative's Signature:	Date:

- If you are applying for Supplemental Nutrition Assistance Program (SNAP) and are receiving or have applied for Supplemental Security Income (SSI) while in an institution, the date of the application will be the date of the release from the institution.
- By applying, you may be eligible to receive information on services to assist families with children so that children may continue to be cared for in their home. Please call the child abuse/neglect hotline for additional information at 800-652-1999.

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Call: 1.800.383.4278. In Lincoln: 402.323.3900. **In Omaha:** 402.595.1258. **Fax:** 402.742.2351.

Cell Phone Number:	Message Phone Number:	Best Time to Call for Interview:
Landline Phone Number:	**TTY/TDD Phone Number:**	
		Do you need a face-to-face interview? ☐ Yes ☐ No
Email Address:		**Do You Prefer Notification Via:**
		☐ Email ☐ Email & Text ☐ Mail ☐ Mail & Text

By selecting an email notification option, you elect to receive notification of your written notices and other correspondence regarding your benefits from DHHS through the above email address. These benefits include; Medicaid, CHIP, SNAP, ADC, LIHEAP, CC Subsidy, AABD payment and SSAD. You will no longer receive information through the mail. You understand you will receive an email notification of the correspondence, which will provide a link to the DHHS ACCESSNebraska website where you can access the correspondence. You understand that you must create an authenticated account on the ACCESSNebraska website in order to view your correspondence in Benefit Inquiry.

By selecting a text notification option, you agree to receive text messages on the above cell phone number from DHHS regarding your benefits. These benefits include; Medicaid, CHIP, SNAP, ADC, LIHEAP, CC Subsidy, AABD payment and SSAD. You agree to contact DHHS if your cell phone number changes or if this number is no longer in your possession. You understand that you can opt out of this in the future by contacting DHHS.

Total household gross income (Employment before any payroll deductions, Social Security, Child Support, Veteran's benefits, Unemployment, etc.) for this month: $ _____

Total household cash/savings for this month: $ _____

Is your household's gross monthly income plus your resources less than your monthly rent or mortgage and utilities? ☐ Yes ☐ No

Monthly rent or mortgage you are responsible to pay: $ _____

Do you have an eviction notice? ☐ Yes ☐ No

Is anyone in your household a migrant or seasonal farm worker whose cash and savings are $100 or less and whose income has recently stopped? ☐ Yes ☐ No If Yes who: _____

Select all utilities you pay for or incur: ☐ Gas ☐ Electricity ☐ Telephone ☐ Sewage/Water ☐ Fuel ☐ Heating/Cooling ☐ None ☐ Other: _____

Have your heating or cooling utilities been shut off? ☐ Yes ☐ No

Do you have a heating or cooling utility disconnect or shut off notice? ☐ Yes ☐ No

Are you out of, or nearly out of your heating fuel/source (20% or less)? ☐ Yes ☐ No

Do you anticipate removal from your heating or cooling utility provider's budget plan? ☐ Yes ☐ No

Legal Designees/Contacts		Designee's Name:	Phone Number:
Does anyone have a Guardian, Conservator or Power of Attorney? ☐ Yes ☐ No	**If yes:**		
Do you want to designate someone to use your Electronic Benefits Transfer (EBT) Card on your behalf? ☐ Yes ☐ No	**If yes:**		
Do you want to provide an emergency contact? ☐ Yes ☐ No	**If yes:**		

If additional space is needed in the following sections, provide information on a separate paper and attach to application.

Household Members

Provide information on all people who live at your address. Include anyone who lives with you even if they are not applying for benefits. Failure to provide an SSN will result in the denial of SNAP benefits to each individual failing to provide an SSN. Any SSNs provided will be used and disclosed in the same manner as SSNs of eligible household members.

Full Legal Name First, Middle, Last, Suffix:	Relationship to Applicant:	Date of Birth:	Age:	Social Security Number:	Sex:	Marital Status:	US Citizen:	Are You Applying for Benefits for this Person?	Does this Person Buy and/or Share Food with You?
	Self				☐ M ☐ F		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
					☐ M ☐ F		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
					☐ M ☐ F		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
					☐ M ☐ F		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

					☐ M ☐ F		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
					☐ M ☐ F		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
					☐ M ☐ F		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
					☐ M ☐ F		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If additional space is needed in the following sections, provide information on a separate paper and attach to application.

Non-Citizen Household Members

Include a copy of the front and back of your US Citizenship and Immigration Services (USCIS) card. Your alien status may be subject to verification by USCIS. The submitted information received from USCIS may affect your eligibility or level of benefits. If the non-citizen has a sponsor, you will be asked to provide more information about the sponsor.

Name of Non-Citizen:	Immigration Status:	Alien Number:	Date of Entry:	Does He/She have a Sponsor?	Does He/She Need Medical Assistance?	Has He/She been a Victim of Human Trafficking?
				☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Previous Names or Aliases

Has anyone in the household had another name or alias? ☐ Yes ☐ No
If yes, please provide information below for this person(s).

Name of Person with other Name or Alias:	Other Names and/or Aliases:

Assistance from Another State

Has anyone in the household ever received assistance from another state? ☐ Yes ☐ No
If yes, please provide information below for this person(s).

Name of Person who Received Assistance:	Did He/She Receive Food, Cash or LIHEAP Assistance?	When did He/She Receive Assistance? (Month(s) and Year(s):	What State(s) did He/She Receive Assistance from?
	☐ Food ☐ Cash ☐ LIHEAP		
	☐ Food ☐ Cash ☐ LIHEAP		
	☐ Food ☐ Cash ☐ LIHEAP		

Pregnancies

Is anyone in the household pregnant? ☐ Yes ☐ No
If yes, please provide information below for this person(s).

Who is Pregnant?	Due Date:	Other Parent:

Children with a Parent Living Outside the Home

Do any of the children living in the home have a parent living outside of the home? ☐ Yes ☐ No
If yes, please provide information on the next page for this person(s). In order to receive SNAP, ADC or Child Care Assistance, you must cooperate with Child Support Enforcement. If it is determined that a household member is not cooperating, that person will be ineligible for SNAP and Child Care and the ADC grant may be reduced by 25%. If cooperation may result in harm to you or your child(ren), or if you have other good reasons why you cannot cooperate, please let us know. You may be asked to provide evidence in order to show good cause for noncooperation. If it is determined that a household member is not cooperating, the child(ren) for whom that parent is not cooperating for will be ineligible for Child Care.

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Name of Child with Parent Outside the Home:	Name of Parent Living Outside the Home:	Address of Parent Living Outside the Home:	Phone of Parent Living Outside the Home:	Other Information You can Provide (Ex: Birthdate, Employer, Employer Address or Phone Number):

Foster Care

Is anyone in the household currently in foster care or ever been in foster care? ☐ Yes ☐ No

If yes, who? _____

If additional space is needed in the following sections, provide information on a separate paper and attach to application.

Disabilities

Does Anyone in the Household have a Disability? ☐ Yes ☐ No

If yes, please provide information below for this person(s).

Name of Person with Disability:	Does He/She Need Help with Self-Care, such as Bathing, Dressing, Eating, etc.?	Has He/She Applied for Social Security Income (SSI) with the Social Security Administration (SSA)?	Was His/Her Application Denied by SSA for Duration, because the Disability would Not Last Longer than 12 Months?	Are You Requesting Medical Coverage for Him/Her?	Does He/She Need Help Paying Medical Bills from the Past 3 Months?
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Was an accident the reason for their disability? ☐ Yes ☐ No *If yes, person's name and date of accident:* _____

Is an insurance company involved? ☐ Yes ☐ No *If yes, name of company:* _____

Medical Assistance (for SDP and RRP applicants only)

Is anyone in the household needing medical assistance? ☐ Yes ☐ No *If yes, who?* _____

Military Information

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

Have you or any member of your household served in any branch of the military? ☐ Yes ☐ No

If yes, please provide information below for this person(s).

Name of Person in the Military or Spouse or Child of a Veteran:	He/She is a:		
	☐ Veteran	☐ Spouse of Veteran	☐ Active
	☐ Child of Veteran (*18 or younger*)		☐ Reserve
	☐ Veteran	☐ Spouse of Veteran	☐ Active
	☐ Child of Veteran (*18 or younger*)		☐ Reserve
	☐ Veteran	☐ Spouse of Veteran	☐ Active
	☐ Child of Veteran (*18 or younger*)		☐ Reserve

Native American Tribe Information

Is anyone in the household a member of a Native American Tribe? ☐ Yes ☐ No

If yes, please provide information below for this person(s).

Name of Person who is a Member of a Native American Tribe:	Specify Native American Tribe(s):

Food Distribution Program on Indian Reservations Program

Has anyone in the household been receiving or is currently receiving commodities through the Food Distribution Program on Indian Reservations (FDPIR) Program? ☐ Yes ☐ No
If yes, please provide information below for this person(s).

Name of Person who has been or is Currently Receiving Commodities:	On what Date did He/She Receive Commodities?	Has He/She Ever Been Disqualified from Receiving Commodities Through the Tribal FDPIR Program?	Specify Native American Tribe(s)	On what Date did this Happen?

If additional space is needed in the following sections, provide information on a separate paper and attach to application.

Education

For SNAP only, Is anyone in the household, ages 18 thru 49, currently attending school? ☐ Yes ☐ No
For all other programs, is anyone in the household, ages 5 thru 49, currently attending school? ☐ Yes ☐ No
If yes, please complete the following for each student.

Name of Person Attending School:	Name of School:	City of School:	Type of School:	If In College	
				Is He/She Attending Full-Time or Part-Time?	Is He/She Participating in Work Study?
			☐ Preschool ☐ Elementary ☐ Middle School ☐ High School ☐ Undergraduate ☐ Graduate	☐ Full-time ☐ Part-time	☐ Yes ☐ No
			☐ Preschool ☐ Elementary ☐ Middle School ☐ High School ☐ Undergraduate ☐ Graduate	☐ Full-time ☐ Part-time	☐ Yes ☐ No
			☐ Preschool ☐ Elementary ☐ Middle School ☐ High School ☐ Undergraduate ☐ Graduate	☐ Full-time ☐ Part-time	☐ Yes ☐ No
			☐ Preschool ☐ Elementary ☐ Middle School ☐ High School ☐ Undergraduate ☐ Graduate	☐ Full-time ☐ Part-time	☐ Yes ☐ No

Additional Household Information

Copy of conviction paperwork	Yes/No	Name of Person:	Date:	County/State:
Is anyone in the household fleeing to avoid prosecution or custody/ confinement after conviction for a felony crime?	☐ Yes ☐ No			
Is anyone in the household in violation of probation or parole?	☐ Yes ☐ No			
Has Anyone in the Household Been:	**Yes/No**	**Name of Person:**	**Date:**	**County/State:**
Convicted of a felony (after 8/22/96) for possession, sale, use or distribution of a controlled substance?	☐ Yes ☐ No			
	Type of Conviction:			
If yes, was a drug treatment program completed?	☐ Yes ☐ No	**Provide the date completed and facility:**		

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	Yes/No	Name of Person:	Date:	County/State:
Convicted of using and/or receiving SNAP benefits in exchange for firearms, ammunition, or explosives (after 9/22/96)?	☐ Yes ☐ No			
Convicted of fraudulently receiving duplicate SNAP benefits in any state (after 9/22/96)?	☐ Yes ☐ No			
Found guilty of buying or selling SNAP benefits of $500 or more (after 9/22/96)?	☐ Yes ☐ No			
Found to have misrepresented identity or residence in order to obtain multiple SNAP, Temporary Assistance for Needy Families (TANF), LIHEAP, and/or LIHWAP benefits at the same time (after 9/22/96)?	☐ Yes ☐ No			
Convicted of trading or attempting to trade SNAP benefits for drugs (after 9/22/96)?	☐ Yes ☐ No			
Has anyone in the household been convicted of a felony for aggravated sexual abuse, sexual exploitation or abuse of a child, sexual assault, murder, or a comparable state felony offense on or after February 8, 2014?	☐ Yes ☐ No			
If yes, is this person in compliance with the terms of their sentence?	☐ Yes ☐ No			
Disqualified in one of the following programs: Aid to Dependent Children (ADC) or TANF/SNAP/Child Care Subsidy/LIHEAP/LIHWAP (Examples of disqualification: being found through an administrative hearing or court of law to have intentionally provided false information)?	☐ Yes ☐ No			
	Program(s):		**Duration:**	

INCOME

List income received by each household member who is requesting assistance, including children. **You may need to provide documentation verifying income for each household member.**

If additional space is needed in the following sections, provide information on a separate paper and attach to application.

Current Jobs

Is anyone in the household working? ☐ Yes ☐ No

If yes, please complete boxes below for the last 30 days of income (before taxes and deductions).

Proof of employment from last 30 days, such as a pay stub.

CURRENT JOB 1: Name of person working:		**Name on paystubs, if different:**	
Employer name:		**Employer phone number:**	
Pay rate: $ _____ Per: ☐ Hour ☐ Day ☐ Week ☐ Month ☐ Year		**Average tips/commission amount per week:** $ _____	
Average hours worked per week:		**Average days worked per week:**	
Have your hours worked changed in the last 30 days? ☐ Yes ☐ No	☐ Increased ☐ Decreased	**Date hours changed:**	
How much gross income did this person receive from this job within the past 30 days? $ _____		**How often is this person paid?** ☐ Daily ☐ Weekly ☐ Monthly ☐ Every 2 weeks ☐ Twice a month ☐ Yearly	

CURRENT JOB 2: Name of person working:		**Name on paystubs, if different:**	
Employer name:		**Employer phone number:**	
Pay rate: $ _____ Per: ☐ Hour ☐ Day ☐ Week ☐ Month ☐ Year		**Average tips/commission amount per week:** $ _____	
Average hours worked per week:		**Average days worked per week:**	
Have your hours worked changed in the last 30 days? ☐ Yes ☐ No	☐ Increased ☐ Decreased	**Date hours changed:**	

How much gross income did this person receive from this job within the past 30 days? $ _____	**How often is this person paid?** ☐ Daily ☐ Weekly ☐ Monthly ☐ Every 2 weeks ☐ Twice a month ☐ Yearly

CURRENT JOB 3: Name of person working:		**Name on paystubs, if different:**	
Employer name:		**Employer phone number:**	
Pay rate: $ _____ Per: ☐ Hour ☐ Day ☐ Week ☐ Month ☐ Year		**Average tips/commission amount per week:** $ _____	
Average hours worked per week:		**Average days worked per week:**	
Have your hours worked changed in the last 30 days? ☐ Yes ☐ No		☐ Increased ☐ Decreased	**Date hours changed:**
How much gross income did this person receive from this job within the past 30 days? $ _____		**How often is this person paid?** ☐ Daily ☐ Weekly ☐ Monthly ☐ Every 2 weeks ☐ Twice a month ☐ Yearly	

If additional space is needed in the following sections, provide information on a separate paper and attach to application.

Ended Jobs

Has anyone in the household quit or ended a job in the past 30 days?
☐ Yes ☐ No *If yes, please complete below.*
Proof of employment from last 30 days.

Is any household member on strike? ☐ Yes ☐ No *If yes, please complete below.*

ENDED JOB 1: Name of person who left a job:	**Name on paystubs, if different:**
Employer name:	**Employer phone number:**
Date job ended:	**Date final pay was received:**
Gross amount of final pay (before payroll deductions): $ _____	**Reason this person's job ended:**

ENDED JOB 2: Name of person who left a job:	**Name on paystubs, if different:**
Employer name:	**Employer phone number:**
Date job ended:	**Date final pay was received:**
Gross amount of final pay (before payroll deductions): $ _____	**Reason this person's job ended:**

Self-Employment Income

Please check the boxes next to any of the following income sources you or anyone in your household has received in the last 30 days or longer if still currently self-employed but have not received recent income:

Proof of gross income, such as self-employment ledgers or tax forms.

☐ In-home business
☐ Farming or ranching
☐ Selling goods such as make-up or kitchenware
☐ Selling things online or websites such as eBay or Craigslist
☐ Providing services such as babysitting, CHORE/PAS, adult/child care, cleaning, etc.
☐ Donating/selling plasma
☐ Other self-employment: _____

If you have checked any of the above, please complete the section below. If there is more than one type of self-employment, please provide the information for each business on a separate piece of paper.

Who is self-employed?	**Date started:**
Name of business:	**Is this business a corporation or partnership?** ☐ Yes ☐ No

Last month's gross income of this business: $ _____	Does the business have expenses? ☐ Yes ☐ No

Other Income

Does you or anyone in your household receive or has applied to receive other income? ☐ Yes ☐ No

Proof of source and amount of other income.

Please check the box next to any other sources of income you or anyone in your household applied for or received in the past 30 days.

☐ Adoption Subsidy
☐ Alimony
☐ Assistantship/Stipend/Fellowship
☐ Child Support
☐ Disability Benefits
☐ Dividends/Interest
☐ Financial Aid
☐ Foster Care Subsidy
☐ Gifts/Donations/Online Contributions
☐ Gambling/Lottery Winnings
☐ Loans
☐ Military Compensation
☐ Other Cash Received Monthly
☐ Railroad Retirement
☐ Rental Income
☐ Retirement/Pension
☐ Social Security Benefits (SSA or RSDI)
☐ Supplemental Security Income (SSI)
☐ Survivor Benefits
☐ Unemployment Benefits
☐ Worker's Compensation
☐ Other

If you have checked any of the above, please complete the section below:

Who has Income?	Source of Income:	Average Monthly Amount:	How often does He/She Receive this Income?
		$	
		$	
		$	

Have you or anyone in your household received a lump sum payment in the past 30 days? ☐ Yes ☐ No

This can include: lawsuit or insurance settlements, Social Security, SSI, RSDI, Veterans Benefits, inheritance, surrender of annuity, or life insurance, etc.

If yes, please complete below.

Who had a Lump Sum Payment?	Date Received:	Source of Lump Sum:	Amount:	Will He/She Receive this Payment again?
			$	☐ Yes ☐ No

RESOURCES

List all resources you or anyone in the household owns or shares with another person.
You must include resources owned jointly with household and non-household members and any resources owned by children.

We may require documentation verifying resources for each household member.

If additional space is needed in the following sections, provide information on a separate paper and attach to application.

ACCOUNTS: Do you or anyone in the household have any of the following resources? ☐ Yes ☐ No

If yes, check all that apply below and complete the account information.

☐ Cash
☐ Debit Cards
☐ Checking/Savings Accounts
☐ Retirement Accounts
☐ Property (Land, Homes)
☐ Mutual Funds
☐ Certificate of Deposits (CD)
☐ Proceeds from Sale of Home(s)
☐ Annuities
☐ Education Accounts
☐ Stocks/Bonds
☐ 401(K)
☐ Trusts
☐ Other

Name(s) on the Account:	Account Type:	Name of Bank Account/Funds:	Amount or Value of Account:
			$
			$
			$
			$

VEHICLES: Does anyone own a car, truck, van, boat, motorcycle, RV, or trailer? ☐ Yes ☐ No

If yes, list them below. Licensed and unlicensed items must be listed.

Name(s) on the Title:	Make/Model and Year:	Amount/Value:	Amount Owed on Vehicle:	Usage:
		$	$	

		$	$	
		$	$	

Is anyone buying or does anyone own land, a property, a house, a rental property, a timeshare, a lot, or a cabin anywhere?
☐ Yes ☐ No
If yes, list them below.

Name(s) on Deed/Title	Property Address/Description:	Assessed Value:	Amount Owed on Property:
		$	$
		$	$
		$	$

Does anyone in the household have Whole Life Insurance, Term Life Insurance or a Burial Trust? ☐ Yes ☐ No
Copy of Policy.

Who Owns the Policy?	Type of Policy:	Value:
		$
		$
		$

Have you or anyone in the household given away anything of significant value or sold anything for less than fair market value in the past 5 years? ☐ Yes ☐ No
If only applying for SNAP, only list items sold, traded or given away in the last 3 months.

Who Sold/Traded/Gifted an Item?	What was Sold/Traded/Gifted?	What Date was it Sold/Traded/Gifted?	Amount Received/Value:
			$
			$
			$

EXPENSES

Only reported and/or verified expenses will be counted and used to determine the amount of benefits you and your household members may receive. Please complete sections below based on the expenses you or anyone in the household is billed.

If additional space is needed in the following sections, provide information on a separate paper and attach to application.

PROPERTY: Does anyone in the household pay rent, mortgage, second mortgage, lot rent, condominium fees, property taxes (if not included in mortgage), home insurance (if not included in mortgage), or other property bills?
☐ Yes ☐ No *If yes, complete below.*

Who Pays:	Type of Property Expense:	How often Billed?	Amount Billed?
			$
			$

Do the Above Expenses Include any of Additional Fees? (Pet, Cable, Garage, etc.)	☐ Yes ☐ No	If Yes, list fees:

MEDICAL: Does anyone in the household who is disabled or is 60 years or older pay insurance premiums, insurance co-pays, prescription medications, Medicare costs or other medical related expenses?
☐ Yes ☐ No *If yes, complete below.*
Proof required of any medical expenses within the last 3 months, such as insurance/bank statements, pharmacy receipts, etc.

Who Pays:	Type of Medical Expense:	How often Billed?	Amount Billed?

			$
			$
			$

CHILD OR ADULT CARE: Does anyone in the household pay for child care, adult care, child support or other child or adult care related expenses? ☐ Yes ☐ No *If yes, list them below.* In order to receive SNAP, you must cooperate with Child Support Enforcement. If it is determined that a household member is not cooperating, that person will be ineligible for SNAP. If cooperation may result in harm to you or your child(ren), or if you have other good reasons why you cannot cooperate, please let us know. You may be asked to provide evidence in order to show good cause for noncooperation.

Proof required of monthly expense, such as receipts, contracts, etc.

Who Pays:	Type of Care Expenses:	How often Billed?	Amount of Bill:
			$
			$
			$

HEATING: Provide information below about your household's heating provider (natural gas, electric, propane, coal, fuel oil, kerosene, wood, or any other sources).
Copy of bill must be provided if applying for LIHEAP.

Last billing statement with current household address, provider name, account name, and account number.

Name on the Bill:	Type of Heating Source:	Provider Name:	Account Number:

COOLING: Provide information below about your household's cooling provider *(electric or any other sources).*
Copy of bill must be provided if applying for LIHEAP.

Last billing statement with current household address, provider name, account name, and account number.

Name on the Bill:	Type of Cooling Source:	Provider Name:	Account Number:

LIHEAP: Please list anyone in the household who has received more than $20 in LIHEAP funds in the current month or last 12 months:

HELP WITH EXPENSES:
Have you or anyone in the household received help paying for any of your rent, mortgage, property taxes, medical care, heating, or cooling expenses in the last 12 months? ☐ Yes ☐ No *If yes, list them below.*

Who Helped with Expenses?	What Expense did they Pay?	How Much did they Pay	Was this a Loan or Gift?
		$	☐ Loan ☐ Gift
		$	☐ Loan ☐ Gift

CHILD CARE QUESTIONS

TOTAL RESOURCES:

☐ **In order to receive Child Care Subsidy, I certify that the total of my family's resources are valued less than one million dollars.**

In order to receive Child Care Subsidy check <u>one</u> of the following:

- ☐ Yes, I agree to have my child or children receive shots to protect against diseases (such as measles, chicken pox) or infections in accordance with State of Nebraska immunization guidelines.
- ☐ No, my religious beliefs do not allow shots.
- ☐ No, these shots would harm my child's medical condition. (This requires a doctor's statement).

Child Care Provider Name:	Provider ID: (If Available)	Address:	Phone Number:

Reason(s) for Needing Child Care:

Developmental screenings are used to help identify any concerns in their current development and can lead to better outcomes as your child grows. Developmental screenings are also valuable to help parents understand their child's developmental needs. Screenings can be completed by your pediatrician or you can contact 402-471-9152 to receive a parent screening tool.

☐ **Check the 'box' if you would like to be contacted and sent more information.**

OPTIONAL DEMOGRAPHICS

Ethnicity:	Race:
☐ Not of Hispanic, Latino, or Spanish origin ☐ Mexican ☐ Puerto Rican ☐ Central American ☐ Cuban ☐ South American ☐ Other Hispanic, Latino, or Spanish Origin ☐ Other/Unknown	☐ Black/African American ☐ White/Caucasian ☐ Asian ☐ American Indian ☐ Alaskan Native ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Other/Unknown

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 benefits are distributed without regard to race, color, national origin, age, disability, sex, gender identity, religion, reprisal and where applicable, political beliefs, marital status, familial or parental status, sexual orientation or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the department. If you do not enter any information, the worker will enter an answer.

☐ I authorize the Nebraska Department of Health and Human Services (DHHS) to release information regarding my current SNAP enrollment to the Nebraska Public Service Commission to determine my eligibility for the Lifeline program or Nebraska Telephone Assistance Program (NTAP). I understand that this identifies me as an individual that receives SNAP benefits. The Nebraska Public Service Commission can condition my eligibility for the Lifeline/NTAP program on the agreement of signing this application and agreeing to the release of information. This authorization is effective for and shall expire one year from the date of this application. This authorization can be revoked at any time by submitting a written request in accordance with the then current DHHS Notice of Privacy Practices (if to DHHS), or by submitting a written request to the Nebraska Public Service Commission it will be honored with the exception of information that has already been released. I understand that if I revoke this authorization DHHS will not be able to confirm my enrollment in the SNAP program. The recipient of this information may no longer be required by privacy laws to protect it. This information is protected by state and federal laws (including 42 CFS Part 431, Subpart F).

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

WHAT SHOULD I KNOW
Rights and Responsibilities

PLEASE KEEP THIS FOR YOUR INFORMATION

By completing and signing the Nebraska Economic Assistance Application for Benefits (EA-117) and other documents required to determine whether I am eligible for economic assistance benefits AND by accepting benefits that I am eligible to receive, I understand the following information and agree to the following requirements.

- I must tell the truth. It is a crime to lie on this application.
- I may have to give papers that show what I have told you is true.
- I may have to tell you of any changes to the information I gave you on my application.
- If I think DHHS made a mistake, I can ask for an appeal or fair hearing.
- DHHS will not discriminate.
- DHHS will confirm citizenship and immigration status for everyone applying for benefits.
- DHHS will take back any benefits you should not have received.
- DHHS will tell you when your benefits will decrease or be terminated.

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 to you.
- Have your application for SNAP processed in accordance with SNAP procedures including within 7 days of the application received date for expedited benefits and 30 days of the application received date for regular benefits.
- Have your application for SNAP benefits considered, regardless of whether or not you have been denied benefits from other programs.

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 DHHS.
- 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 recipients of medical services.
- Cooperate with Nebraska Child Support Enforcement.
- Ask questions if you do not understand something about medical assistance

REPORTING CHANGES FOR AABD, ADC, SDP, AND RRP

Report all changes within 10 days to DHHS such as:

- Changes in the household, such as when someone moves in or out.
- If you move.
- New employment.
- Termination of employment, including job training or other work activities.
- Change in the amount of monthly income.
- Reduction or increase in the number of hours worked per week.
- For Child Care subsidy, any change which requires additional or fewer authorized hours.
- Changes in disability or incapacity.
- A change in health insurance.
- A change in a resource, (such as getting a new vehicle or a change in your bank account).

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

REPORTING CHANGES FOR CHILD CARE SUBSIDY PROGRAM

Changes in income that exceed 85% of the State Median Income must be reported to the agency within 10 days of the change. The State Median Income Limits can be found at http://dhhs.ne.gov/Pages/Guidance-Documents.aspx.

If your current need for service ends and it is not a temporary change, this must be reported to the agency within 10 days of the change.

If you move out of the state of Nebraska you must report this to the agency within 10 days of the change.

REPORTING CHANGES FOR SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)

There are two reporting categories in SNAP. 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 understanding your notice or reporting category, contact DHHS or go online at: www.ACCESSNebraska.ne.gov and select "Report Changes."

ELECTRONIC BENEFITS (EBT) CARD

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

If a retailer has to complete a manual transaction, called a voucher, due to a problem with the host system and they obtain authorization for the transaction; the voucher will be presented for payment of funds from your EBT account. If you have insufficient funds to cover the payment, you will be notified and the voucher may be re-presented for payment in a subsequent month(s). Re-presentation of vouchers is not allowed due to problems with EBT card, PIN Pad or card reader errors, or POS terminal malfunction.

If you believe you have been overcharged for SNAP benefits by a retailer, you may file a dispute with the card vendor. To do so, call EBT Customer Service at (877) 247-6328, and from the main menu choose your food transactions. Find the transaction you would like to dispute and select the option to dispute the charges.

If you received goods but were not charged by the retailer, the retailer may request an adjustment to your account by filing an adjustment request with the card vendor. You will be notified of the retailer adjustment request. If you agree to the adjustment, you do not have to take any action. If you request a fair hearing within 15 days of the notice, you will receive a provisional credit pending the hearing.

RESTRICTIONS ON THE USE OF ELECTRONIC BENEFITS

NOTICE: If you receive your ADC, AABD, SDP, RRP, or LIHEAP benefits via the ReliaCard-debit card, please know that it is a violation of federal law and/or state regulation to access these funds from an ATM located at or via a point-of-sale purchase at the following types of businesses:

1. Liquor stores;
2. Casino, Gambling Casino or Gaming Establishment; oR
3. Any retail establishment which provides adult-oriented entertainment in which performers disrobe or perform in an unclothed state for entertainment.

CHILD SUPPORT ENFORCEMENT (CSE)

Eligibility Requirements: As a condition of eligibility, ADC, SNAP, 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.

Benefits of Child Support Services: Your cooperation with the 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 CSE, 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 CSE 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.

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.

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

Custodial Parents and Non-Custodial Parents:

1. Establishment of paternity; and
2. Establishment, modification, or enforcement of an order.

Good Cause Circumstances: You should contact your Child Support Enforcement worker immediately if at any time you believe that cooperation, 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 Enforcement 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 noncustodial party's name and address, to help the investigation.
- If it is necessary to contact the non-custodial parent as 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
- Loss of SNAP eligibility for yourself

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 $35.00 yearly fee once $550 of support has been disbursed, unless the payee meets one of the exemptions below. When a minimum of $550 has been disbursed, the next collection(s) will be retained by the Nebraska Department of Health and Human Services, and applied towards the $35.00 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;
- Fee was assessed and collected in another state during current Federal Fiscal Year; or
- SNAP recipients subject to cooperation provisions for SNAP eligibility.

It is your responsibility to notify the CSE office if your case qualifies as an exception as listed above.

Use of Social Security Numbers: 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 number only for the purpose of establishing and enforcing support.

NEBRASKA LOW INCOME HOME ENERGY ASSISTANCE PROGRAM (LIHEAP)

LIHEAP payments will be sent to utility providers in most circumstances. If a household receives LIHEAP payments directly, they must agree to take full responsibility for paying utility bills. By applying for or receiving LIHEAP, the household understands that the information collected for LIHEAP program eligibility and the household's LIHEAP eligibility status may be disclosed to energy programs, utility providers, weatherization providers, and fan providers. DHHS may share and use information collected for purposes of evaluating and administering LIHEAP.

LIHEAP WARNING

Individuals who have knowingly provided false information may be subject to disqualification from LIHEAP due to an Intentional Program Violation (IPV). A person who commits an IPV is ineligible as follows:

a. A person is ineligible for LIHEAP during the period the person is disqualified from receiving other economic assistance benefits due to an IPV in another program.
b. A person who commits a LIHEAP IPV is ineligible as follows:
    - For a first IPV, the person becomes ineligible for any LIHEAP benefits for the remainder of the program year and the next full program year.

- For a second IPV, the person becomes ineligible for any LIHEAP benefits for the remainder of the program year and the next three full program years.
- For a third (and any subsequent) IPV, the person becomes permanently ineligible for LIHEAP benefits.

The entire household is ineligible for LIHEAP crisis assistance to pay any bill incurred during any period a household member is under a sanction for an IPV.

AID TO DEPENDENT CHILDREN (ADC) CHILD CARE PENALTY

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.

NOTICE : If you receive your TANF (Temporary Assistance for Needy Families – ADC) benefits via an electronic benefit transfer/debit card (ReliaCard), please know that it is a violation of Federal law to access these funds from an ATM located at or via a point-of-sale purchase at the following types of businesses:

- Liquor stores;
- Casino, Gambling Casino or Gaming Establishment; or
- Any retail establishment which provides adult-oriented entertainment in which performers disrobe or perform in an unclothed state for entertainment.

ADC 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.

ADC INFORMATION DISCLOSURE

By applying for the ADC Program, the applicant(s) understands that the information collected on the application form, as well as ADC program eligibility information may be disclosed to partners of the Workforce Innovation and Opportunity Act (WIOA) programs pursuant to 34 CFR 361.38(e). DHHS may share and use information collected for purposes of referral, research, evaluation and analysis.

ASSISTANCE AVAILABLE FOR VICTIMS OF SEXUAL HARASSMENT AND SURVIVORS OF DOMESTIC VIOLENCE, SEXUAL ASSAULT, OR STALKING.

If you are a victim of sexual harasment or a survivor of domestic violence, sexual assault, or stalking and need assistance for services available in Nebraska, contact ACCESSNebraska at 1-800-383-4278, your assigned DHHS worker, or your Employment First Case Manager.

SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP) 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 a felony or misdemeanor for an additional 18 months. Individuals convicted of trafficking benefits for an aggregate amount of $500 or more will be permanently ineligible to participate in SNAP upon the first occasion of such violation. Individuals found guilty of using and/or receiving and/or attempting to use and/or receive SNAP benefits in exchange for firearms, ammunition or explosives, will be permanently ineligible for SNAP upon the first occasion of such violation. Individuals convicted of a misdemeanor or felony for trading or attempting to trade SNAP benefits for drugs will be ineligible for SNAP for 24 months for the first violation, and permanently ineligible for the second violation. If you are found to have made a fraudulent statement or representation with respect to the identity or place of residence in order to receive multiple SNAP benefits simultaneously, you will be ineligible to participate in the Program for a period of 10 years.

DO NOT:

- Give false, incorrect, or incomplete information to attempt to obtain or continue to obtain SNAP benefits.
- Trade or sell or attempt to 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.
- Pay for food purchased on credit with SNAP benefits. Doing so could result in disqualification.

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 August 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 September 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.

SNAP IMMIGRATION STATUS

The alien status of applicant household members may be subject to verification by USCIS 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.

SNAP 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.

CHILD CARE SUBSIDY PROGRAM

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; children who turn age 13 during their eligibility period remain eligible through the end of their eligibility period; 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 2-013, which includes:

- 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 and child care;

- Actively Seeking Employment – Each time the recipient loses employment, the recipient is entitled to three months of child care to seek employment. Child care for job search activities cannot be authorized at initial application except when job search is required by a federally funded workforce program;

- 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;

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

- 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 in-person classes, it can be authorized for two hours per week for each credit hour. 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).

- Participation in on the job training;

- 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

- Meets the definition of homeless. Child care may be authorized up to forty hours per week for the duration of the eligibilty period to provide stability to the individual's children and to allow the parent or usual caretaker the opportunity to seek out community resources.

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 case 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 7 PM or before 7 AM), overnight, weekend, or holidays 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.

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 or orally. Your case may be presented by a household member or a representative, such as a legal counsel, a relative, a friend or other spokesperson. You may continue to receive your current level of assistance, known as continuation of benefits, 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

For purposes of calculating the deadlines described above, the mail date is not counted. If the last day of the 10 or 90-day periods fall on a Saturday, Sunday, or state holiday, the deadline is extended to the next business day.

If a hearing request is made within the notice of adverse action period and your certification period has not expired, participation will be continued at the same level of benefits, unless you waive continuation of benefits. If you do not waive your right to continuation of benefits in writing, the Department will assume you wish benefits to continue and will issue the benefits accordingly. If the Department's action is upheld by the hearing decision, the Department will initiate a claim against the household for repayment of all funds received.

Within 60 days of receipt of a request for a fair hearing, the Department will assure the hearing is conducted, a decision is reached, and the household and agency are notified of the decision by an order. The household member or representative is entitled to one postponement of a maximum of 30 days of the scheduled hearing if the request for postponement is made at least ten days before the scheduled hearing.

The household may withdraw a fair hearing request, orally or in writing, any time before a determination of the fair hearing is made. If the withdrawal request is made verbally, the office will provide written notice to the household within ten days of the household's request to withdraw, confirming the withdrawal request and providing the household an opportunity to request another hearing if desired. A household is allowed one reinstated fair hearing per appeal.

CIVIL RIGHTS

Do Not Send Applications Here.

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Programs that receive federal financial assistance from the U.S. Department of Health and Human Services (HHS), such as Temporary Assistance for Needy Families (TANF), and programs HHS directly operates are also prohibited from discrimination under federal civil rights laws and HHS regulations.

Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

USDA provides federal financial assistance for many food security and hunger reduction programs such as the Supplemental Nutrition Assistance Program (SNAP), the Food Distribution Program on Indian Reservations (FDPIR) and others. To file a program complaint of discrimination, complete the Program Discrimination Complaint Form, (AD-3027) found online at: https://www.usda.gov/sites/default/files/documents/ad-3027.pdf, and at any USDA office or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a

copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) Food and Nutrition Service, USDA, 1320 Braddock Place, Room 334, Alexandria, VA 22314; or

(2) fax: (833) 256-1665 or (202) 690-7442; or

(3) phone: (833) 620-1071

(3) email: FNSCIVILRIGHTSCOMPLAINTS@usda.gov

For any other information regarding SNAP, persons should either contact the USDA SNAP hotline number at (800) 221-5689, which is also in Spanish or call the state information/hotline numbers (click the link for a listing of hotline numbers by State); found online at: fns.usda.gov/snap/state-directory.

HHS provides federal financial assistance for many programs to enhance health and well-being, including TANF, Head Start, the Low Income Home Energy Assistance Program (LIHEAP), and others. If you believe that you have been discriminated against because of your race, color, national origin, disability, age, sex (including pregnancy, sexual orientation, and gender identity), or religion in programs or activities that HHS directly operates or to which HHS provides federal financial assistance, you may file a complaint with the Office for Civil Rights (OCR) for yourself or for someone else.

To file a complaint of discrimination for yourself or someone else regarding a program receiving federal financial assistance through HHS, complete the form online through OCR's Complaint Portal at https://ocrportal.hhs.gov/ocr/. You may also contact OCR via mail at: Centralized Case Management Operations, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F HHH Bldg., Washington, D.C. 20201; fax: (202) 619-3818; or email: OCRmail@hhs.gov. For faster processing, we encourage you to use the OCR online portal to file complaints rather than filing via mail. Persons who need assistance with filing a civil rights complaint can email OCR at OCRMail@hhs.gov or call OCR toll-free at 1-800-368-1019, TDD 1-800-537-7697. For persons who are deaf, hard of hearing, or have speech difficulties, please dial 7-1-1 to access telecommunications relay services. We also provide alternative formats (such as Braille and large print), auxiliary aids and language assistance services free of charge for filing a complaint.

This institution is an equal opportunity provider.

SOCIAL SECURITY NUMBER/CITIZENSHIP

The DHHS asks for Social Security Numbers (SSNs) of all individuals for whom assistance is requested as required by the federal Social Security and Food Stamp Acts. Individuals who are not applying for assistance for themselves are not required to have or provide an SSN. If the individual is financially responsible for others in the assistance unit, the SSN will be used 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 provides his/her SSN will be computer matched with the following programs to assist in the determination of eligibility: Vital Statistics, Unemployment Compensation, Employment, Child Support, Resources, Income, Social Security Benefits (RSDI), Supplemental Security Income (SSI), and Veterans Benefits. These services will be verified by information received from the following agencies: 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 and could affect the kind and amount of assistance individuals receive. 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. 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 individual and to verify income.

If you are applying for SNAP benefits or Child Care Assistance, this application asks you to tell us about the citizenship and immigration status of people in your household. For Child Care Assistance, you must tell us about the citizenship or immigration status for the children who will receive assistance. This application also asks you to give us SSNs for everyone in the household. We use SSNs to help us verify information such as income. If anyone in your household does not have an 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. If some family or household members do not wish to apply for SNAP benefits, 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.

The collection of this information, including the social security number of each household member, is authorized under the Food and Nutrition Act of 2008, as amended, 7 U.S.C. 2011-2036. The information will be used to determine whether your household is eligible or continues to be eligible to participate in SNAP. We will verify this information through computer matching programs. This information will also be used to monitor compliance with program regulations and for program management. Providing the requested information, including the SSN of each household member, is voluntary. However, failure to provide an SSN will result in the denial of SNAP benefits to each individual failing to provide an SSN. Any SSNs provided will be used and disclosed in the same manner as SSNs of eligible household members.

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

SDP AND RRP MEDICAL

Third Party Liability: Individuals who receive Medical Assistance 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 DHHS in establishing paternity, and cooperate with DHHS in obtaining any available third party payments such as an insurance payment or court settlement. Medicare benefits are not assigned. Individuals must cooperate with 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. DHHS will waive the requirement to cooperate if it determines that the individual has good cause for refusing to cooperate. If 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 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 persons. 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 recipients must release them to DHHS. This information will be used as provided in the Notice of Information Privacy Practices.

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

Medical Services:

- Present proof of your current 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 DHHS determines it is cost effective.
- Agree to comply with managed care requirements.
- Pay the costs 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 that your coverage is through DHHS.
- Failure to follow certain conditions may result in your being responsible to pay the bills.

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 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.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Nebraska Department of Health and Human Services (DHHS) and those agencies inclusive of health care facilities and medical assistance programs that are affiliated under the common control of the 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 without your consent for purposes of:

- Treatment: We may use your medical information to provide you with medical treatment or services. We may share your information with a nurse, medical professional or other personnel who are giving you treatment or services. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. Different agencies within DHHS may share your medical information in order to coordinate the different things you need, or to support and maintain your continuum of care.
- 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 the hospital can be reimbursed.
- Operations: We may use and disclose medical information about you for health care 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/AUTHORIZATION:

- 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 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: 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.
- Specialized Government Functions: When the appropriate conditions apply, we may use or disclose Protected Health Information of individuals who are Armed Forces personnel for military, national security, and intelligence activities. Protected Health Information may be disclosed for the administration of public benefits purposes.
- 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: 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.

USES AND DISCLOSURES REQUIRING AUTHORIZATION:

There are certain uses and disclosures of Protected Health Information that require your authorization. Among them are: most uses and disclosures of psychotherapy notes; uses and disclosures of protected health information for marketing purposes; and disclosure of protected health information that constitutes a sale.

Other uses and disclosures not described in this notice will be made only WITH authorization from you. You may revoke this authorization at any time as provided by 45 CFR 164.508(b)(5).

YOUR RIGHTS TO PRIVACY:

- Right to Inspect and Copy. You have the right to inspect and copy your medical information. Usually, this includes medical and billing records but does not include psychotherapy notes. To inspect and copy your medical information, you must submit a written request at the Site of Service or to the DHHS HIPAA Privacy & Security Office. If you request a copy, we may charge a fee for the cost of copying, mailing, and other supplies associated with your request. We may deny your request to inspect and copy in certain circumstances. If you are denied access to medical information, you may request the denial be reviewed.
- Right to Amend. If you feel that medical information about you is incorrect or incomplete, you may ask us to amend (correct) 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 DHHS HIPAA Privacy & 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 a list of the disclosures we made of medical information about you. You must submit your request in writing at the Site of Service, or to the DHHS HIPAA Privacy & Security Office. 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.
- 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, health care operations, and to someone who is involved in your care or the payment of your care, like a family member or friend. We are not required to agree to your request for restrictions unless it is for payment or health care operations and you

use your own funds to pay, in full, for a health care item or service. 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 DHHS HIPAA Privacy & Security Office. 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.

- 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. To request confidential communications, you must make your request in writing at the Site of Service, or to the DHHS HIPAA Privacy & Security Office. Your request must specify how or where you wish to be contacted.
- Right to a Paper Copy of this Notice. You have a right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our website, http://dhhs.ne.gov/Pages/hipaa_hp-1-p-notice.aspx or by contacting us.
- Opt out of fund-raising communications. If DHHS should conduct fund-raising activities, you have a right to opt out of this communication.
- Breach notification. In the event DHHS breaches your unsecured protected health information as defined by HIPAA, you will receive notification of the breach.

COMPLAINTS

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 the DHHS HIPAA Privacy & Security Office. 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), 1-866-778-4989-TTY. You will not be penalized for filing a complaint. [6]

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 either electronically or in paper format.

CONTACT INFORMATION

This notice fulfills the “Notice” requirements of the Health Insurance 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 DHHS please direct them to: HIPAA Privacy and Security Office, 301 Centennial Mall South 3rd Floor, Lincoln, NE 68509-5026, by phone at 402-471-8417, or by email to DHHS.HIPAAOffice@nebraska.gov. If you have question about your benefits call 800-383-4278.

Effective 9/23/2013