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

Department of Health and Human Services
Disabled Persons & Family Support Program (DPFS)

Service & Device Application - Self-Assessment

SECTION I APPLICANT INFORMATION (Complete for person with special needs or disability)

Last Name:	First Name:	MI:	Nickname:
☐ Male ☐ Female	Date of Birth:	Social Security Number:	

Address:	City:	State: Nebraska	Zip:	County:
Phone:	Email:	Can Program Staff contact you via email: ☐ Yes ☐ No		
Primary Caregiver Name:	Does the primary caregiver live with the applicant ☐ Yes ☐ No			

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated

Ethnicity/Primary Race:
☐ American Indian/Native Alaskan ☐ Asian/Pacific Islander ☐ Hispanic ☐ White (non-Hispanic)
☐ African-American ☐ Multi-Racial ☐ Other:

Veteran (Spouse of): ☐ Yes ☐ No
Branch of Service:

Dates of Service:	Veteran has a service-connected disability: ☐ Yes ☐ No

Receiving Veterans' Administration Services: ☐ Yes ☐ No
Describe if no, why not:

For the purpose of complying with Neb. Rev. § 4-108 through 4-114, I attest as follows:

My Immigration Status: ☐ I am a US Citizen - OR - ☐ I am a qualified alien under the federal Immigration and Nationality Act	Alien Number

Speaks English: ☐ Yes ☐ No	Language Spoken:

SECTION II FUNCTIONAL ASSESSMENT

Check the boxes that best describe the level of assistance required for each activity.

Self Care and Capacity for Independent Living

Activity	Can Do Independently	Need Help Monthly but not Weekly	Need Help Weekly but not Daily	Need Help Daily	If Currently Receiving Help, Who Helps You	What Disability Limits this Activity
Eating means assistance needed to complete the process of eating. Includes assistance with hand washing and application of orthotics required for eating. Includes supervision related to chewing/swallowing issues, choking and monitoring intake.						
Bathing means assistance with basic personal hygiene and skin care including starting and completing the steps of a bath or shower.						

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Activity	Can Do Independently	Need Help Monthly but not Weekly	Need Help Weekly but not Daily	Need Help Daily	If Currently Receiving Help, Who Helps You	What Disability Limits this Activity
Grooming/Hygiene means assistance with basic hair care, oral care, and shaving, applying cosmetics, deodorant and basic nail care. Care of eyeglasses and hearing aids.						
Dressing means assistance with choosing, dressing and changing of clothing and application of special appliances wraps or clothing (e.g. TED hose).						
Toilet Use means assistance with bowel or bladder elimination and care including transfers, mobility, positioning, feminine hygiene, use of toileting equipment and supplies, cleansing the perineal area, infection of the skin and adjusting clothing.						
Mobility means help with walking or use of a wheelchair or walker.						
Transferring means assistance with positioning or turning a person for necessary care and comfort.						
Medical Transportation means help is needed getting to/from disability related medical appointments.						
Medication Management means help is needed to safely take medicine as prescribed by a medical professional.						
Essential Shopping means help is needed with the physical ability to go through a store for necessary items, not related to transportation.						
Financial Management/ Bill Paying						
Routine Light Housekeeping means help is needed with laundry, vacuuming, dishes, etc.						

Other Major Life Activities:						
Activity	**Can Do Independently**	**Need Help Monthly but not Weekly**	**Need Help Weekly but not Daily**	**Need Help Daily**	**If Currently Receiving Help, Who Helps You**	**Comments**
Receptive and Expressive Language (the ability to get your meaning or message across to others or to understand a message conveyed to you).						
Learning (the ability to acquire information the same as other peers in the same age range).						
Self-Direction (the ability to act on one's own behalf, solve problems and make informed decisions).						
Work skills: The ability to tolerate work. If this is impaired have you applied for Social Security Disability but were denied ☐ Yes ☐ No						

Adaptive Equipment				
Equipment	**Has**	**Has But Does Not Use**	**Needs**	**Comments**
Bathing Equipment				

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Equipment	Has	Has But Does Not Use	Needs	Comments
Brace, Prosthesis				
Cane, Crutches				
Diabetic Supples				
Dentures				
Railings, Grab Bars				
Hospital Bed				
Lift System				
Medical Phone Alert, Lifeline				
Toilet/ Bathing Assistance Equipment				
Walker				
Manual or Motorized Wheelchair				
Access Equipment (access to/ from home, bathroom)				

Are you currently receiving Home Delivered Meals? ☐ Yes ☐ No

Check the days you receive delivered meals:
☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat

Who provides the meals?	Your cost for each meal?

Has your doctor recommended any special diet(s): ☐ Yes ☐ No

Comments:

Meal Preparation

Because of chronic medical need or disability, do you need help preparing food? ☐ Yes ☐ No

Do you currently have help? ☐ Yes ☐ No

If yes, who helps prepare your meals? ☐ Family/Spouse ☐ In-Home Worker

What Meal(s):

Breakfast:	☐ S	☐ M	☐ T	☐ W	☐ Th	☐ F	☐ Sa
Lunch:	☐ S	☐ M	☐ T	☐ W	☐ Th	☐ F	☐ Sa
Dinner:	☐ S	☐ M	☐ T	☐ W	☐ Th	☐ F	☐ Sa

Check any item(s) that affect your ability to eat:

☐ Choking ☐ Nausea/Vomiting ☐ Vision
☐ Swallowing ☐ Cutting Up Food ☐ Dentures (Lack of or Poor Fitting)
☐ Taste ☐ Opening Containers ☐ None

SECTION III MEDICAL NEEDS

Receiving Hospice Services? ☐ Yes ☐ No

List all medications you currently take. Please include all prescribed, over the counter medications/supplements.

Date Started	Name of Medication and Dose	Prescribing Doctor	Disability the Medicine Treats

Allergies:

Self-Management of Medications

Do you take your medications as prescribed? ☐ Yes ☐ No

If not, why? ☐ Personal Choice ☐ No Insurance Coverage/Can't Afford ☐ Forget

If you take medication regularly, do you need reminders? ☐ Yes ☐ No

If so, check any of the following reminders that you use:
☐ Calendar ☐ Pill Box/Dispenser ☐ Egg Carton/Envelope/Bag ☐ Person reminds/gives/sets up

Who provides help with this medicine?

Cognitive Needs

(Check Yes or No to each question)

No noticeable memory problems: ☐ Yes ☐ No

Occasionally forgetful: ☐ Yes ☐ No

Frequently forgets information about friends, family, news, events, etc.: ☐ Yes ☐ No

Gets confused: ☐ Yes ☐ No

Gets lost: ☐ Yes ☐ No

Wanders during the night: ☐ Yes ☐ No

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Fall Risk Screen	
How many times have you fallen in the past year?	Did a fall cause an injury? ☐ Yes ☐ No
Are you worried that you might fall? ☐ Never ☐ Occasionally ☐ Sometimes ☐ Often	
Do you limit activities now because of fall-related concerns: ☐ Never ☐ Occasionally ☐ Sometimes ☐ Often	

Medical Personnel		
Primary Doctor:	Doctor's Phone:	
Specialist(s):		
Name:	Area of Speciality:	Phone:
Pharmacy(ies):		
Name:		
Name:		
Name:		
Dentist:	Dentist's Phone:	
In-Home Provider Name:	In-Home Provider Phone:	In-Home Provider Email:

Medical Transportation Needs	
Do you drive? ☐ Yes ☐ No	
Do you have a car? ☐ Yes ☐ No	
If yes, is the car registered and has the minimal insurance required by law? ☐ Yes ☐ No	
If applicant has a car but does not drive, does someone else drive you to medical appointments? ☐ Yes ☐ No	
If yes, who drives?	Driver's Relationship to Applicant:
Is any program paying for or assisting with your medical transportation? ☐ Yes ☐ No	
If yes, who?	
Can you walk from inside your home to the curb? ☐ Yes ☐ No	
Can you carry 10 pounds without assistance? ☐ Yes ☐ No	
If you need a vehicle with a wheelchair lift do you have access to one? ☐ Yes ☐ No	

Section IV ECONOMIC SUFFICIENCY/FINANCIAL ELIGIBILITY INFORMATION*
Single adults (19 years of age or older with no minor children) should list only your income. Families should list income of married couples or income of the adults, including wages of children ages 14 - 18.
Gross (before deductions) Monthly Income: $

Service & Device Application - Self-Assessment

Sources (Check all that apply):

- ☐ Annuities or Insurance
- ☐ Interest or Dividends
- ☐ Pension or Retirement Account
- ☐ Social Security Disability Benefits
- ☐ Unemployment Insurance or Worker's Compensation
- ☐ Child Support or Alimony
- ☐ Land Lease Income
- ☐ Railroad Retirement
- ☐ Social Security Retirement
- ☐ Employment Wages
- ☐ Rental Income
- ☐ Self-Employment Wages
- ☐ Subsidized Adoption Payment
- ☐ Veterans Benefits
- ☐ Farming Income

Source	Amount	How Often Received	Who Receives It

Assets

List financial assets readily available:

- ☐ Annuities
- ☐ Education Savings Account(s)
- ☐ Mutual Funds
- ☐ Savings Account(s)
- ☐ 401(K)
- ☐ Cash
- ☐ Proceeds from Sale of Property or Home
- ☐ Stocks, Bonds
- ☐ Certificates of Deposit (CD)
- ☐ Farmland
- ☐ Trust(s)
- ☐ Checking Account(s)
- ☐ Inheritance
- ☐ Property (Land, Home)
- ☐ Whole Life Insurance

Also list liquid assets that can be converted to cash without incurring a substantial penalty. Exceptions: 401(K) or employment retirement accounts for owners not of retirement age and educational savings account(s) for children or grandchildren. Attach additional sheet if needed.

Source	Type	Value

*Attach to Application/Assessment the following documents: copy of your most recent Social Security Award letter (if applicable), verification of earned income (wages/farming income/self-employment income/rental property income/land lease income/pension-retirement-railroad) and unearned income (Social Security disability or retirement benefits/alimony/child support/veterans disability benefits/unemployment insurance/worker's compensation/trust fund) and resources, verification of cash value of life insurance policies, proof of interest and dividends of savings/investments/annuities, verification of disability-related expenses.

Do you have a Burial Fund*?

☐ Yes ☐ No Irrevocable? ☐ Yes ☐ No Current Cash Value $

Beneficiary(ies) Name, Relationship (Primary):

Beneficiary(ies) Name, Relationship (Secondary):

*Submit documentation of this asset:

Insurance

☐ Health Insurance (Carrier(s):

☐ Medicaid (Provider Number):

☐ Share of Cost Amount (if any):
$

☐ Medicare (Check all that apply): ☐ Part A ☐ Part B ☐ Part C ☐ Part D

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Unreimbursed Out Of Pocket Expenses Related To Your Disability

List expenses paid by applicant and not reimbursed by or paid for by insurance or any public/private program funds. Expenses must be related to your disability. General medical expenses or insurance premiums are not eligible. Do not include expense of other family members. Supporting documentation is required. Note: A minimum of three months out of pocket costs is needed to determine an average out of pocket cost.

Expense	Chronic Medical Condition or Disability the Expense is Related to	Frequency of Payment	Total Annual Payment

Household Members

Name	Relationship to Applicant (wife, daughter, son, partner, grandparent, etc.)	Date of Birth

Living Arrangement of Applicant:
☐ House ☐ Duplex ☐ Apartment ☐ Moblie Home ☐ Senior Housing ☐ Assisted Living

Residence is:
☐ Owned ☐ Rented ☐ Other:

☐ Adult Living Alone
☐ Adult Living with Unrelated Adult
☐ Child Living with Biological Parents
☐ Child Living with Unrelated Adult(s)
☐ Adult Living with Relative
☐ Child Living with Adoptive Parents
☐ Child Living with Grandparent(s)
☐ Adult Living with Spouse

Relative(s) Receiving DPFS Services

Relationship:

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 ☐ Active ☐ Spouse of Veteran ☐ Reserve ☐ Child of Veteran *(18 or younger)*
	☐ Veteran ☐ Active ☐ Spouse of Veteran ☐ Reserve ☐ Child of Veteran *(18 or younger)*
	☐ Veteran ☐ Active ☐ Spouse of Veteran ☐ Reserve ☐ Child of Veteran *(18 or younger)*

Section V PRIMARY CAREGIVER INFORMATION (Answer only if primary caregiver lives with applicant)

Does the caregiver have help caring for the applicant? ☐ Yes ☐ No

If the person/people who help are not available, are there others who assist if asked? ☐ Yes ☐ No

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Check limitations or constraints of primary caregiver:

- ☐ No particular constraint
- ☐ Provides care to others
- ☐ Poor relationship with applicant
- ☐ Financial strain
- ☐ Poor health, disabled, frail
- ☐ Not reliable due to other commitments
- ☐ Lives at a distance
- ☐ Dependent on applicant for housing, money or other
- ☐ Lacks knowledge, skills
- ☐ Employed
- ☐ Alcohol, drug abuse

Current primary caregiver, employment status:

☐ Full time ☐ Part-time ☐ Unemployed ☐ Retired ☐ Ended employment to care for applicant

Has primary caregiver's job or social life been affected by caregiver duties? ☐ Yes ☐ No

Does primary caregiver have other caregiving responsibilities? ☐ Yes ☐ No

How many hours a day does primary caregiver have available to provider care to applicant?

How many hours a day does primary caregiver usually spend providing care to applicant?

Describe problems with continued caregiving (if any)?

Overall how stressed is the primary caregiver? ☐ Not stressed ☐ Somewhat stressed ☐ Very stressed

Does the primary caregiver need respite services (temporary break from full-time caregiving)? ☐ Yes ☐ No

Are you currently receiving Lifespan Respite Subsidy? ☐ Yes ☐ No

SECTION VI RELEASE/AGREEMENT AND SIGNATURE

I understand that my statements may be checked, and if I have given false statements or information, I may be found guilty of fraud.

I understand that whenever there are changes in the information I have given, I must immediately report them to the DHHS DPFS Program staff.

I understand that if I do not think my application is handled correctly, I have the right to file an appeal.

I understand DHHS may need to contact other agencies and individuals to determine my DPFS eligibility for which I am applying, or to make referrals to assist me in obtaining services. I authorize DHHS to release and receive confidential information for such purposes.

Payments for benefits may be delayed if I did not provide my Social Security number.

I hereby attest that my response and the information provided on this form and any related application for public benefits are true, complete and accurate and I understand that this information may be used to verify my lawful presence in the United States.

I also authorize DHHS to release and share information regarding my DPFS application and eligibility on my behalf with the following family members and individuals:

Signature of Applicant (or Authorized Person):	**Date:**

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Person Assisting with Application/Assessment (Referral Source)		
Name:		
Relationship to Applicant/Legal Role of Authorized Person:		
Agency (if any):		
Agency Address:		Agency City:
Agency Zip:	Agency Email:	Agency Phone:

Return this completed application/assessment form and supporting documents to:

1. Email: dhhs.DPFS@nebraska.gov
2. Mail: Department of Health & Human Services
   Division of Children & Family Services, Economic Assistance
   Disabled Persons and Family Support Program
   P.O. Box 98933
   Lincoln, NE 68509-8933
3. Fax: (402) 742-8396

Questions: toll-free 1-844-807-1197 or in Lincoln (402) 471- 9220

Instructions

Instructions for completing Form DPF-3 Revised 11/2014, "Disabled Persons and Family Support Program (DPFS) Service and Device Application – Self Assessment"

Use: Form DPF-3 Revised 11/2014 is used as an application to determine eligibility for the Disabled Persons & Family Support Program benefits. Program staff will use the form to collect data needed to determine eligibility of individuals of all ages who meet income, disability, and need criteria for DPFS services. It also serves as a release of information when additional information is needed to determine program eligibility. This program is intended to provide minimal financial support to people with disabilities to maintain or obtain employment, maintain independence and prevent institutionalization. The state-funded Program does not operate as an entitlement and services are intended to supplement, but not reduce the responsibility for the services and supports available through other programs for which the family or person with a disability may be eligible such as Medicaid, Social Services Block Grant, Administration on Aging or other programs with Federal funding. DHHS Manual reference 472 NAC Chapter 1 through Chapter 4.

Completion: Program staff will use the data to determine eligibility. Incomplete information may delay eligibility determination. The application must be signed and dated by applicant or his/her authorized representative.

Section 1: APPLICANT INFORMATION (Person with special needs or disability): Enter the name, gender, date of birth, social security number, address, city, zip code, county, phone number, email address (indicate if contact via email is allowed), name of primary caregiver and indicate if primary caregiver lives with the applicant.

Marital Status: Check the status that applies.

Ethnicity/Primary Race: Check the status that most closely applies.

Veteran (Spouse of): Check yes or no and provide answers to questions. Write "n/a" if no military service.

Immigration Status and Alien Number: Check status. If a qualified alien, provide immigration status and alien number. Indicate spoken language(s).

Meal Preparation: Check the choice(s) to each question that best describes your special needs.

Section II FUNCTIONAL ASSESSMENT: This information is used to support need for specific program services. Check the box to each question that best describes the level of help you need for each activity.

Check the yes or no check box that applies to each question. If receiving home delivered meals, mark the days they are delivered. Answer additional questions. Write "n/a" if you do not receive home delivered meals or doctor has not recommended a special diet.

Section III: MEDICAL NEEDS: This information is used to supplement Form DPF-1 "DPFS Disability Report" and determine need for program services.

Hospice Services: Check yes or no.

Medications: Provide details of current medications taken. Incomplete information may delay eligibility determination.

Allergies: List known allergies.

Self-Management of Medications: Check the choice(s) to each question that best describes your special needs.

Cognitive Needs: Check the choice(s) to each question that best describes your special needs.

Fall Risk Screen: Check the choice(s) to each question that best describes your special needs.

Medical Personnel: Provide contact information. Incomplete information may delay eligibility determination.

Medical Transportation Needs: Check the choice(s) to each question that best describes your special needs.

Section IV ECONOMIC SUFFICIENCY/FINANCIAL ELIGIBILITY INFORMATION: Information used to determine financial eligibility. Verification of income, resources and reported disability-related expenses is required.

Gross (before deductions) Monthly Income: List income and mark all sources that apply.

Assets: Check all sources of assets. List by source, type and current value.

Burial Fund: Check if you have a fund in place and whether it is irrevocable. List the cash value and beneficiary/relationship.

Insurance: List details of policies.

Unreimbursed Out of Pocket Related To Your Disability (per form) Disability-Related Expenses: Provide details of disability-related expenses paid on behalf of the applicant in a year's time. Do not include medical or household costs not related to disability reported on application/assessment. Do not include expenses for household members. Amounts covered by insurance or paid by benefit programs will not be considered. Information listed here will be considered to see if the expense may be disregarded from the income.

Living Arrangement of Applicant: Check the choices that best describes your home and who you live with.

Relatives with DPFS Services: List any family members receiving services past or present.

Section V PRIMARY CAREGIVER INFORMATION: Answer questions only if primary caregiver lives with applicant. This information is used to offer access to respite resources and support to full-time unpaid family caregivers through the Nebraska Lifespan Respite Network.

Section VI RELEASE/AGREEMENT AND SIGNATURE: The applicant or authorized representative must sign the application/assessment before Program staff can determine eligibility. Anyone assisting with completing the application must sign and list relationship, date, address, email and telephone.