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

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

Application Pre-Screening Tool

1 **SECTION I – DPFS Pre-Screen**

Use the following pre-screening tool to identify other aid programs that should be pursued before DPFS.

Screening Instructions: The DPFS Program is secondary to other programs. DPFS eligibility may only be determined after other forms of aid have been denied or are unavailable at programmatic capacity. Documented eligibility status for other programs will be requested if not submitted. Other assistance programs may exist that are not listed below.

Primary Assistance Programs: Individual applies for first-line programs if they have not already.

Individual receives written eligibility determinations from primary assistance programs.

DPFS: Individual submits eligibility determination documents to DPFS.

Other Assistance Programs

MEDICARE: Does this individual have Medicare?
Medicare is the federal health program for people 65 and older, and for people who have received Social Security Disability for 24 months.
☐ Yes ☐ Pending ☐ Denied
☐ Closed ☐ Has not applied ☐ Unsure
Reason for closure:
_____

If enrolled in Medicare, select the coverage received:
☐ Original Medicare: Standard plan that includes Part A (Hospital) and Part B (Medical) coverage
☐ Medicare Advantage: Part C
☐ Medicare Prescription Drug: Part D
☐ Medicare Supplement: Medigap
Medicare Plan Letter (e.g. Plan G, F, N): _____

OTHER MEDICAL / HEALTH INSURANCE:
☐ Private/Workplace ☐ Long-Term Care
☐ No health insurance ☐ Unsure
Carrier:_____

ASSISTANCE TO THE AGED, BLIND, or DISABLED (AABD) PROGRAM:
☐ Enrolled ☐ Not enrolled
Monthly standard: $_____
Special requirements: $_____

VETERANS AFFAIRS (VA):
☐ Insurance ☐ Financial Assistance
☐ Assistance Services ☐ No benefits through VA

SOCIAL SERVICES FOR AGED and DISABLED ADULTS (SSAD) PROGRAM: Is the applicant enrolled in SSAD?
☐ Yes ☐ Pending ☐ Denied ☐ Unsure
☐ Closed/stopped services ☐ Has not applied
Reason for closure:
_____

MEDICAID: Does this individual have Medicaid?
☐ Yes ☐ Pending ☐ Denied
☐ Closed ☐ Has not applied ☐ Unsure
Reason for closure:
_____

If yes, please select the type(s) of coverage received:
☐ Full-Benefit Medicaid (doctor's visits, prescriptions, etc.)
Indicate the applicant's Heritage Health Plan:
☐ Nebraska Total Care ☐ Molina Healthcare
☐ United Healthcare Community Plan

☐ Full-Benefit Medicaid, but with a Share of Cost:
Monthly out-of-pocket cost before Medicaid pays:
$_____ per month

☐ Medicare Savings Program (QMB, SLMB, QI-1, QDWI)
Medicaid helps with Medicare costs (e.g. Part B)

☐ QMB Plus or SLMB Plus
Full-benefit Medicaid and Medicare Savings Program

MEDICAID PERSONAL ASSISTANCE SERVICES (PAS): Is the applicant receiving personal assistance services?
☐ Yes ☐ Pending ☐ Denied ☐ Unsure
☐ Closed/stopped services ☐ Has not applied
Reason for closure:
_____

HOME and COMMUNITY- BASED SERVICES WAIVER:
☐ Aged and Disabled (AD) Waiver
☐ Traumatic Brain Injury (TBI) Waiver
☐ Developmental Disabilities Waivers (FSW, CDD, DDAD)
☐ Pending ☐ Has not applied
☐ Denied ☐ Unsure
☐ Closed/stopped services
Reason for closure:
_____

ASSISTIVE TECHNOLOGY PARTNERSHIP (ATP): Has the applicant worked with an ATP Technology Specialist?
☐ Yes ☐ No Name:_____

2 SECTION II – Applicant Information

☐ **This individual completed the DPFS Pre-Screening Tool before starting this application.**

Last Name:	First Name:	MI:	Other Alias Used:

Social Security Number:	Date of Birth:	Gender:

Email:	Phone:	How may DPFS staff contact you?

Client Ethnicity/Primary Race:

☐ American Indian/Native Alaskan ☐ African-American ☐ Hispanic ☐ White (non-Hispanic)

☐ Asian/Pacific Islander ☐ Multi-Racial ☐ Other:_____

Client Immigration Status (Neb. Rev. Stat. §§ 4-108 to 4-114):	Alien Number:
☐ I am a US Citizen **-OR-** ☐ I am a qualified alien under the federal Immigration and Nationality Act	

Speaks English:	Primary Language Spoken:	Assistive Communication:
☐ Yes ☐ No		☐ American Sign Language (ASL) Interpretation ☐ Telecommunications Relay Service (TTY / TRS)

Applicant Residence and Mailing Addresses

Residential Address:	City:	State:	ZIP:	County:

☐ Applicant's mailing address is the **same** as their residential address

☐ Applicant's mailing address is **different** than their residential address

Mailing Address:	City:	State:	ZIP:	County:

Which DPFS services will the applicant request through the Program?

☐ Personal Care (activities of daily living)
☐ Medical Mileage Reimbursement
☐ Assistive/Adaptive Equipment
☐ Home or Vehicle Modifications
☐ Disability-Related Counseling or Training
☐ Housekeeping (light cleaning, essentials shopping)
☐ Disability-Related Medical, Surgical, Diagnostic, Therapeutic, or other Physical or Mental Health Services
☐ Medications/Prescriptions (for disabling condition)
☐ Medical Supplies (for disabling condition)

Is the applicant utilizing any other programs to receive one or more of the above services?

☐ Applicant **is currently receiving** services through another program (open/active).
☐ Applicant **has applied to receive** services through another program (pending).
☐ Applicant **was denied** services by all other programs.
☐ Applicant **has stopped receiving** services through another program (closed).

List other programs being received, applied for, denied, or closed:	**OR** ☐ Applicant has not applied for any of the above services through another program.

3 SECTION III – Applicant Representative and Caregiver

(472 NAC 02, 03)

DPFS is a self-directed program in which recipients direct their care, review the accuracy of provider billing, and confirm that authorized services are delivered (472 NAC 03-004, 03-006). The Department authorizes payment only for services that are properly documented and verified (472 NAC 03-006). If documents submitted to the Program indicate that an applicant cannot independently direct services or confirm that they were delivered, a representative is elected by a recipient to perform these functions on the applicant's behalf so that service provision can be independently corroborated.

If this DPFS applicant's medical documentation indicates cognitive limitation, **please assign a representative below.**

REPRESENTATIVE TYPE A

☐ **Legal Representative:** This applicant already has a legal representative designated to manage their healthcare, and this person can direct DPFS services.

☐ POA ☐ Guardian ☐ Conservator
☐ Other:_____

☐ I acknowledge that legal documentation signed by the applicant must be provided to the DPFS Program to verify representative authority.

OR

REPRESENTATIVE TYPE B

☐ **Authorized Representative:** This applicant does **not** have a legal representative and will authorize an individual to direct DPFS services.

☐ I acknowledge that DHHS documentation must be signed by the applicant to designate a representative specific to DPFS.

Representative Name:	Phone:	Email:

Representative Address:	City:	State:	ZIP:	County:

Caregiver (The main person who assists the applicant with activities of daily living, not a medical provider)

Does the applicant have a caregiver? *An individual who provides unpaid assistance with activities of daily living. This may include a parent, spouse, guardian, relative, friend, or volunteer.* ☐ Yes ☐ No

Is the caregiver the legal guardian of the applicant? ☐ Yes ☐ No

Caregiver Name:	Caregiver Address:	City, State, ZIP:	Relation to Applicant:

Does the caregiver live with the applicant? ☐ Yes ☐ No

Does the caregiver receive any compensation for their caregiving duties? ☐ Yes ☐ No

Does the applicant receive funds that can be used to compensate their caregiver? ☐ Yes ☐ No

Is the caregiver employed at this time?	Number of hours spent providing care to applicant per week:
☐ Full Time ☐ Part Time ☐ Retirement ☐ Ended employment to care for applicant	

4	SECTION IV – Medical Information (472 NAC 02)		
Medical Providers and Diagnosis			
Medical/Healthcare Provider 1:	Specialty:	Practice Name and City:	Provider Phone:
Medical/Healthcare Provider 2:	Specialty:	Practice Name and City:	Provider Phone:
Medical/Healthcare Provider 3:	Specialty:	Practice Name and City:	Provider Phone:
Medical/Healthcare Provider 4:	Specialty:	Practice Name and City:	Provider Phone:
Medical/Healthcare Provider 5:	Specialty:	Practice Name and City:	Provider Phone:

Diagnosed Health Conditions		
Diagnosis/Condition 1:	☐ Permanent ☐ Temporary	Mode of Treatment/Medication Used to Treat:
Diagnosis/Condition 2:	☐ Permanent ☐ Temporary	Mode of Treatment/Medication Used to Treat:
Diagnosis/Condition 3:	☐ Permanent ☐ Temporary	Mode of Treatment/Medication Used to Treat:
Diagnosis/Condition 4:	☐ Permanent ☐ Temporary	Mode of Treatment/Medication Used to Treat:
Diagnosis/Condition 5:	☐ Permanent ☐ Temporary	Mode of Treatment/Medication Used to Treat:
Diagnosis/Condition 6:	☐ Permanent ☐ Temporary	Mode of Treatment/Medication Used to Treat:
Diagnosis/Condition 7:	☐ Permanent ☐ Temporary	Mode of Treatment/Medication Used to Treat:

5	**SECTION V – Disability, Functional Limitation**
	(472 NAC 01, 02): Responses below must be verified through the DPFS Disability Report

PERSONAL CARE: Is the applicant able to independently perform the following self-care activities?		
Bathing	☐ Can do independently	☐ Cannot do independently
Meal preparation	☐ Can do independently	☐ Cannot do independently
Eating	☐ Can do independently	☐ Cannot do independently
Continence-related tasks	☐ Can do independently	☐ Cannot do independently
Dressing	☐ Can do independently	☐ Cannot do independently
Grooming	☐ Can do independently	☐ Cannot do independently
Taking medication	☐ Can do independently	☐ Cannot do independently
Cognitively manage one's activities of daily living	☐ Can do independently	☐ Cannot do independently

FUNCTIONAL LIMITATIONS: Does the applicant's condition result in limitations in the following activities?			
Receptive/Expressive language	☐ Little to no limitation	☐ Moderate limitation	☐ Substantial limitation
Learning	☐ Little to no limitation	☐ Moderate limitation	☐ Substantial limitation
Mobility	☐ Little to no limitation	☐ Moderate limitation	☐ Substantial limitation
Self-direction	☐ Little to no limitation	☐ Moderate limitation	☐ Substantial limitation
Capacity for independent living	☐ Little to no limitation	☐ Moderate limitation	☐ Substantial limitation
Work skills or work tolerance	☐ Little to no limitation	☐ Moderate limitation	☐ Substantial limitation
Economic sufficiency	☐ Little to no limitation	☐ Moderate limitation	☐ Substantial limitation

DURATION AND TREATMENT: Please select "yes" or "no."		
Is the applicant's qualifying condition(s) expected to continue indefinitely?	☐ Yes	☐ No
Does the applicant require ongoing, coordinated care, treatment, vocational rehabilitation, or other services related to their qualifying condition(s)?	☐ Yes	☐ No

ADAPTIVE EQUIPMENT		
Does the applicant use adaptive equipment to assist with their disability?	☐ Yes	☐ No
Equipment currently used (cane, walker, wheelchair, oxygen, etc.):		
Equipment needed (cane, walker, wheelchair, oxygen, etc.):		

6	**SECTION VI – Household**
	(472 NAC 01, 02): Responses below must be verified through the DPFS Disability Report

HOUSEHOLD SIZE: List every person who resides at the applicant's address, regardless of age, relationship, or tax filing.

Full Name (first and last)	**Relationship to Applicant**	**Date of Birth**	**Do they also have a diagnosed disability?**
Applicant:	Is: *Self*		☐ Yes ☐ No
Spouse (if married):	Is: *Legal spouse*		☐ Yes ☐ No
Parent (leave blank if no parent resides):	Is: *Parent* ☐ Mother ☐ Father		☐ Yes ☐ No
Parent (leave blank if no parent resides):	Is: *Parent* ☐ Mother ☐ Father		☐ Yes ☐ No
Other:	Is:		☐ Yes ☐ No
Other:	Is:		☐ Yes ☐ No
Other:	Is:		☐ Yes ☐ No
Other:	Is:		☐ Yes ☐ No
Other:	Is:		☐ Yes ☐ No
Other:	Is:		☐ Yes ☐ No
Other:	Is:		☐ Yes ☐ No

Is another individual in the applicant's household applying for DPFS or receiving DPFS services?
☐ Yes ☐ No

Living Arrangement: ☐ Rent ☐ Own ☐ Does not rent or own

Property Type:
☐ House ☐ Apartment ☐ Duplex ☐ Mobile Home ☐ Unassisted Senior Living
☐ Institutional setting (hospital, nursing facility, assisted living, intermediate care facility, regional center, rehabilitation facility)

If currently in an institutional setting, will DPFS assistance help the applicant return home? ☐ Yes ☐ No

7 SECTION VII – Financial Income

Income and Disability-Related Expenses

Please note all income sources collected by the **applicant,** their **legal spouse,** or their **parents** (if applicant is under 19).

Retirement & Fixed Income	Employment & Variable Income	Miscellaneous Income
☐ Social Security Retirement	☐ Employment Wages	☐ Unemployment Insurance
☐ Pension or Retirement Account	☐ Self-Employment Wages	☐ Worker's Compensation
☐ Social Security Disability Benefits	☐ Farming, Trade, or Business Income	☐ Trust Income
☐ Supplemental Security Income	☐ Land Lease Income	☐ Unassigned Alimony
☐ Veterans Benefits	☐ Rental Income	☐ Insurance Payouts (settlements)
☐ Annuity Payments	☐ Interest or Dividends	☐ Gambling / Lottery Winnings
☐ Railroad Retirement	☐ Capital Gains / Investment Payouts	☐ Other:_____

Income Amounts

Income Source A:	Name of Earner:	☐ Applicant ☐ Spouse ☐ Parent ☐ Other	Source A Monthly Gross: $
Income Source B:	Name of Earner:	☐ Applicant ☐ Spouse ☐ Parent ☐ Other	Source B Monthly Gross: $
Income Source C:	Name of Earner:	☐ Applicant ☐ Spouse ☐ Parent ☐ Other	Source C Monthly Gross: $
Income Source D:	Name of Earner:	☐ Applicant ☐ Spouse ☐ Parent ☐ Other	Source D Monthly Gross: $
Income Source E:	Name of Earner:	☐ Applicant ☐ Spouse ☐ Parent ☐ Other	Source E Monthly Gross: $

OR: ☐ No income is earned in the applicant's household.

Disability-Related Expenses

Note: Expenses eligible for consideration are outlined in Title 472 NAC and must be directly related to disabling condition.

Expense: Monthly Cost:	Was this paid out of pocket and not covered by insurance or another program? ☐ Yes ☐ No	Expense: Monthly Cost:	Was this paid out of pocket and not covered by insurance or another program? ☐ Yes ☐ No
Expense: Monthly Cost:	Was this paid out of pocket and not covered by insurance or another program? ☐ Yes ☐ No	Expense: Monthly Cost:	Was this paid out of pocket and not covered by insurance or another program? ☐ Yes ☐ No
Expense: Monthly Cost:	Was this paid out of pocket and not covered by insurance or another program? ☐ Yes ☐ No	Expense: Monthly Cost:	Was this paid out of pocket and not covered by insurance or another program? ☐ Yes ☐ No

8 SECTION VIII – Financial Resources

Assets and Available Funding

Please select and list all types of financial accounts held by the applicant, their legal spouse, or jointly with another person.

☐ Checking ☐ Retirement (401k, IRA, Pension) ☐ Certificate of Deposit ☐ None
☐ Savings ☐ Investment (Stocks, Mutual Fund) ☐ Health Savings Account ☐ Other:
☐ Cash ☐ Annuity (Fixed, Variable) ☐ Educational Savings Account

List Financial Accounts

Account A Type:	Financial Institution:	Account Holder: ☐ Applicant ☐ Joint with spouse ☐ Spouse ☐ Joint with other	Balance: $
Account B Type:	Financial Institution:	Account Holder: ☐ Applicant ☐ Joint with spouse ☐ Spouse ☐ Joint with other	Balance: $
Account C Type:	Financial Institution:	Account Holder: ☐ Applicant ☐ Joint with spouse ☐ Spouse ☐ Joint with other	Balance: $
Account D Type:	Financial Institution:	Account Holder: ☐ Applicant ☐ Joint with spouse ☐ Spouse ☐ Joint with other	Balance: $
Account E Type:	Financial Institution:	Account Holder: ☐ Applicant ☐ Joint with spouse ☐ Spouse ☐ Joint with other	Balance: $
Account F Type:	Financial Institution:	Account Holder: ☐ Applicant ☐ Joint with spouse ☐ Spouse ☐ Joint with other	Balance: $

Insurance, Burial & Trust

Please list **all** related assets held by the applicant, their legal spouse, or jointly with another person.

Asset Type: ☐ Life Insurance (Whole) ☐ Trust ☐ Long-Term Care Policy ☐ Burial Plot ☐ Burial Insurance ☐ Burial Trust ☐ Other Type: _____	Account Holder: ☐ Applicant ☐ Spouse ☐ Joint with spouse ☐ Joint with other Name: _____	This asset is revocable: ☐ Yes ☐ No This is a Special Needs Trust: ☐ Yes ☐ No	Total Value: $ Cash Surrender: $
Asset Type: ☐ Life Insurance (Whole) ☐ Trust ☐ Long-Term Care Policy ☐ Burial Plot ☐ Burial Insurance ☐ Burial Trust ☐ Other Type: _____	Account Holder: ☐ Applicant ☐ Spouse ☐ Joint with spouse ☐ Joint with other Name: _____	This asset is revocable: ☐ Yes ☐ No This is a Special Needs Trust: ☐ Yes ☐ No	Total Value: $ Cash Surrender: $
Asset Type: ☐ Life Insurance (Whole) ☐ Trust ☐ Long-Term Care Policy ☐ Burial Plot ☐ Burial Insurance ☐ Burial Trust ☐ Other Type: _____	Account Holder: ☐ Applicant ☐ Spouse ☐ Joint with spouse ☐ Joint with other Name: _____	This asset is revocable: ☐ Yes ☐ No This is a Special Needs Trust: ☐ Yes ☐ No	Total Value: $ Cash Surrender: $

OR: ☐ I do not possess any of the above insurance, trusts, or burial plot assets.

Office Use:

Property & Real Estate

Please select **all** real estate and property owned by the applicant, their legal spouse, or jointly with another person.

Primary Residence (if applicant owns their home) Address: City/State/ZIP:	Market Value: $	Owner(s): ☐ Applicant ☐ Spouse ☐ Joint ☐ Owned with someone else: _____
Other Property Address: City/State/ZIP:	Market Value: $	Owner(s): ☐ Applicant ☐ Spouse ☐ Joint ☐ Owned with someone else: _____
Type: ☐ Building ☐Land ☐ Other:_____	Is this property essential to a trade or business (e.g., farmland)? ☐ Yes ☐ No	
Other Property Address: City/State/ZIP:	Market Value: $	Owner(s): ☐ Applicant ☐ Spouse ☐ Joint ☐ Owned with someone else: _____
Type: ☐ Building ☐Land ☐ Other:_____	Is this property essential to a trade or business (e.g., farmland)? ☐ Yes ☐ No	
Other Property Address: City/State/ZIP:	Market Value: $	Owner(s): ☐ Applicant ☐ Spouse ☐ Joint ☐ Owned with someone else: _____
Type: ☐ Building ☐Land ☐ Other:_____	Is this property essential to a trade or business (e.g., farmland)? ☐ Yes ☐ No	

OR: ☐ I do not own any property.

Office Use:

Vehicles & Recreational Assets

Please select **all** motorized vehicles owned or leased by the applicant, their legal spouse, or jointly with another person.

Asset Type: ☐ Car/Truck ☐ Other (e.g. RV)	Description (Year/Make/Model):	Asset Owner: ☐ Applicant ☐ Spouse ☐ Joint with:_____	Equity Value: $
Asset Type: ☐ Car/Truck ☐ Other (e.g. RV)	Description (Year/Make/Model):	Asset Owner: ☐ Applicant ☐ Spouse ☐ Joint with:_____	Equity Value: $
Asset Type: ☐ Car/Truck ☐ Other (e.g. RV)	Description (Year/Make/Model):	Asset Owner: ☐ Applicant ☐ Spouse ☐ Joint with:_____	Equity Value: $

OR: ☐ I do not own any vehicles or other recreational assets.

Office Use:

Other/Miscellaneous Resources or Assets

Please list any additional liquid assets or resources available to the applicant.

Resource/Asset Description:	Resource Value: $	Resource/Asset Description:	Resource Value: $
Resource/Asset Description:	Resource Value: $	Resource/Asset Description:	Resource Value: $

RELEASE/AGREEMENT AND SIGNATURE

The Disabled Persons and Family Support (DPFS) Program adheres to regulations outlined in Title 472 Nebraska Administrative Code (NAC). By signing this application, I agree with the statements contained in this agreement. I attest that the information is true, complete, and accurate. I understand that my statements may be checked for accuracy, and, if I have given false information, I may be found guilty of fraud.

I understand that all sections of this application and required documentation must be fully completed, and incomplete applications will be returned and may be denied if the missing items are not provided within ten calendar days of the Department's written request. I understand that each applicant or recipient is required to provide verification of information when requested by the Department, and failure to respond within ten calendar days to written requests for supportive documentation will result in application denial or case closure.

I understand that the DPFS Program is supplemental to other available support programs, and that the applicant or recipient must not be, nor could not be, eligible for another state or federally funded support program that can provide the requested assistance. I attest that I have applied for all other support programs that fund the same or similar services and will provide evidence of eligibility denial or lack of available funds at program capacity. I understand that failure to accept available assistance through or cooperate with other programs may result in denial or termination of DPFS services.

I understand that I must report any change in circumstances listed in regulation, including eligibility for other programs, to the DPFS Program no later than ten calendar days following the change. I understand that applicants, recipients, and authorized representatives have the right to appeal the eligibility determination of the DPFS Program.

I understand that DHHS may need to contact other agencies and individuals to determine my eligibility for the DPFS Program or to make referrals to assist me in obtaining services. I authorize DHHS to release and receive confidential information for these purposes.

I agree to comply with all requirements of Title 472 NAC, Program requests, and state and federal laws.

Signature of Applicant or Legal Representative:	Date:

Person Assisting with Application/Assessment (Referral Source)

☐ This application was not completed or assisted by an individual who is currently providing paid services to the applicant or intends to provide paid services to the applicant if approved.

Name:	Relationship to Applicant/Legal Role:
Email:	Phone:
Agency (if any):	Agency Address (Street, City, State, ZIP):

Which method will you use to submit the DPFS Program application?

☐ **Email:** DHHS.DPFS@nebraska.gov

☐ **Mail:** Department of Health & Human Services
Division of Disability and Aging
Disabled Persons and Family Support Program
P.O. Box 98933, Lincoln, NE 68509-8933

☐ **Fax:** (402) 742-8396

The DPFS Program may be contacted at:

- **Toll-free:** (844) 807-1197
- **Local:** (402) 471- 9188
- **Email:** DHHS.DPFS@nebraska.gov

APPLICATION COMPLETENESS CHECKLIST

All sections of the DPFS Program Application must be completed, and all supporting documents that verify eligibility are required before eligibility can be determined (472 NAC). The DPFS Program highly encourages applicants to submit supporting documents with their application, including verification documents for income, resources, or medical conditions. If any item is missing, DPFS will send a written request for documents to be sent. Applicants will have 10 calendar days from the date of that written request to provide the missing item, or their application may be denied.

For renewal: an applicant's completed DPFS Application, DPFS Disability Report, and supporting documents are due within 45 calendar days of your renewal notice and before your current eligibility period ends, or your case will close (472 NAC).

Document/Requirement	**Applicant Check**
All sections of this application are completed (no blank fields)	☐ Yes
The **DPFS Disability Report** (DPF-2) is completed and signed by a licensed health professional	☐ Yes, I am including it with this application
Copy of the most recent **Social Security award letter**	☐ Yes, I am including it with this application ☐ No, the applicant does not receive social security funding
Verification of all earned and unearned income (may include **official bank statements, pay stubs, tax returns, insurance policies, or other official statements confirming income**)	☐ Yes, I am including it with my application ☐ No, I do not have income (Section 7)
Verification of assets and resources (may include **official bank statements, pay stubs, tax returns, insurance policies, or other official statements confirming income**)	☐ Yes, I am including it with my application ☐ No, I do not own resources (Section 8)
Verification of disability-related expenses (minimum 3 months of documentation, receipts)	☐ Yes, I am including it with my application ☐ No, I am not reporting disability-related expenses
Other Support Program documentation (denial notices, proof of application, or letters of explanation or service unavailability at programmatic capacity)	☐ Yes, I am including it with my application
Applicant/Representative Initials:	**Date:**

INSTRUCTIONS

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

Use: Form DPF-3 is used to determine eligibility for DPFS benefits for individuals who meet the disability, income, and need criteria. It also serves as a release of information when needed to determine eligibility. DPFS is a state-funded program, is not an entitlement, and is secondary to all other available assistance programs: services supplement, but do not replace, supports available through other programs such as Medicaid, Medicare, SSAD, or Veterans Affairs. Governing regulations are found in 472 NAC.

Completion: Every field requires a response; do not leave any field blank. If an item does not apply, mark the "no" or "none" option provided. The application must be signed and dated by the applicant or their legal or authorized representative. Incomplete applications will be returned, and items not provided within 10 calendar days of a written request will result in denial (472 NAC).

Section I - DPFS PRE-SCREENING TOOL: Complete before starting the application, and check the confirmation box at the top of Section II. DPFS eligibility may only be determined after primary assistance programs have been applied for and denied, or unavailable at programmatic capacity. Indicate the applicant's enrollment or application status for each program listed. Documented eligibility status will be requested if not submitted with the application.

Section II - APPLICANT INFORMATION: Provide the applicant's identifying, contact, and address information. Qualified aliens must provide an alien number and immigration documentation. Check each DPFS service requested, then indicate whether the applicant already receives or has applied for any of those services through another program, listing each program.

Section III - APPLICANT REPRESENTATIVE AND CAREGIVER: Applicants with cognitive or communicative limitations designate a representative. Select Type A if a legal representative exists (documentation verifying authority is required) or Type B to authorize a representative specific to DPFS (signed DHHS designation is required). Complete all caregiver questions.

Section IV - MEDICAL INFORMATION: List the applicant's providers and diagnoses, marking each diagnosis permanent or temporary and noting its treatment.

Section V – DISABILITY, FUNCTIONAL LIMITATION: Used to self-assess disability criteria and provide contextual information about the applicant's need for services. Answer every personal care, functional limitation, duration, and adaptive equipment item using the definitions printed in the section.

Section VI - HOUSEHOLD: List every person residing at the applicant's address, regardless of age, relationship, or tax filing status. Complete the living arrangement and property type items.

Section VII - FINANCIAL INCOME: For applicants age 19 or older, report all income of the applicant and their legal spouse. For applicants under age 19 who have not been emancipated, also report the taxable income of the custodial parent(s) (472 NAC 02-007.01). List each source individually, identify whose income it is, and enter the gross (before deductions) monthly amount. Report only disability-related expenses paid out of pocket; only expenses outlined in Title 472 are considered. Verification of all income and expenses is required.

Section VIII - FINANCIAL RESOURCES: Report all accounts, insurance, trusts, burial assets, property, vehicles, and other resources of the applicant and legal spouse, including jointly held assets. If none apply in a category, mark the "I do not" statement. Verification of all resources is required.

RELEASE/AGREEMENT AND SIGNATURE: Read the release in full, sign, and date. Anyone assisting with the application must provide their information. Select a submission method listed on the form.

APPLICATION COMPLETENESS CHECKLIST: Confirm all sections are complete and all supporting documents are included, then initial and date. For renewals, the completed renewal application, disability report, and supporting documents are due within 45 calendar days of the renewal notice or the case will close (472 NAC).