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:

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.

Home Care and Affairs

Activity	Assistance	
HOUSEKEEPING: includes assistance with laundry, vacuuming, dishes, etc.	☐ No need for assistance	☐ Moderate assistance ☐ High assistance
MAINTENANCE: includes assistance with upkeep of residential structure, caretaking of yard, and installation of necessary home modifications.	☐ No need for assistance	☐ Moderate assistance ☐ High assistance
FINANCIAL MANAGEMENT: includes assistance overseeing accounts, managing income, and paying bills.	☐ No need for assistance	☐ Moderate assistance ☐ High assistance
SHOPPING: includes assistance with the physical ability to go through a store for necessary items, not related to transportation.	☐ No need for assistance	☐ Moderate assistance ☐ High assistance
WORK SKILLS: includes the ability to perform functions for employment in gainful positions.	☐ No need for assistance	☐ Moderate assistance ☐ High assistance

SECTION II - FUNCTIONAL ASSESSMENT (CONTINUED)

Interactive and Social Cognition

Activity	Assistance	
LANGUAGE: includes the ability to express and receive language, or to convey and understand meanings or messages.	☐ No need for assistance	☐ Moderate assistance ☐ High assistance
LEARNING: includes the ability to acquire information to the same extent as other peers in similar age ranges.	☐ No need for assistance	☐ Moderate assistance ☐ High assistance
MEMORY: includes the ability to recall events, information, or locations in short-term or long-term situations.	☐ No need for assistance	☐ Moderate assistance ☐ High assistance
SELF-DIRECTION: includes the ability to act on one's behalf, solve problems, and make informed decisions.	☐ No need for assistance	☐ Moderate assistance ☐ High assistance

Personal Care and Independent Living

Activity	Assistance	
BATHING: includes assistance with basic personal hygiene and skincare including starting and completing the steps of a bath or shower.	☐ No need for assistance	☐ Moderate assistance ☐ High assistance
GROOMING/HYGIENE: includes assistance with basic hair care, oral care, shaving, applying cosmetics, deodorant, and basic nail care. Care of eyeglasses and hearing aids.	☐ No need for assistance	☐ Moderate assistance ☐ High assistance
DRESSING: includes assistance with choosing, dressing, and changing clothing and application of special appliances, wraps, or clothing (e.g. TED hose).	☐ No need for assistance	☐ Moderate assistance ☐ High assistance
TOILETING: includes 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.	☐ No need for assistance	☐ Moderate assistance ☐ High assistance
TURNING/POSITIONING: includes assistance with positioning or turning a person for necessary care and comfort.	☐ No need for assistance	☐ Moderate assistance ☐ High assistance
MEAL PREPARATION: includes assistance storing ingredients, preparing food, and cooking.	☐ No need for assistance	☐ Moderate assistance ☐ High assistance
EATING: includes assistance with hand washing and application of orthotics required for eating. Includes supervision related to chewing/swallowing issues, choking, and monitoring intake.	☐ No need for assistance	☐ Moderate assistance ☐ High assistance
AMBULATION: includes assistance with walking or the use of a wheelchair or walker to move throughout home.	☐ No need for assistance	☐ Moderate assistance ☐ High assistance

SECTION III - ASSISTIVE EQUIPMENT

Do you use adaptive equipment to assist with a disability? ☐ Yes ☐ No

If yes, please list the adaptive equipment you use:

Examples could include: bathing equipment, braces, prosthesis, cane, crutches, diabetic supplies, 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), etc.

SECTION IV- MEDICAL PROVIDER AND INSURANCE

Medical Personnel

Primary Doctor:	Doctor's Phone:

Specialist:	**Area of Specialty:**	**Phone:**

Dentist:	Dentist's Phone:

In-Home Provider Name:	In-Home Provider Phone:	In-Home Provider Email:

Are you currently receiving hospice services? ☐ Yes ☐ No

Insurance

☐ Health Insurance (Carrier):

☐ Medicaid (Provider Number): ☐ Share of Cost Amount (if any): $

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

SECTION V - PRIMARY CAREGIVER (Answer only if primary caregiver lives with the applicant)

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

Current primary caregiver, employment status:
☐ Full-time ☐ Part-time ☐ Unemployed ☐ Retired ☐ Ended employment to care for the applicant

How many hours a day does the primary caregiver usually spend providing care to the applicant?	Does the primary caregiver need respite services (temporary break from full-time caregiving)? ☐ Yes ☐ No

Describe problems with continued caregiving (if any)?

SECTION VI - PRESCRIPTION MEDICATIONS

PRESCRIPTIONS: Do you take prescribed drugs?	☐ Yes ☐ No
COST: If yes, do you have medical insurance to cover part or all of your prescription drug costs?	☐ Yes, I have medical insurance that pays for all or part of my prescription drug costs ☐ No, I pay all of my prescription drug costs out-of-pocket ☐ All or part of the cost of my prescription drugs is paid by a program other than insurance

Prescriptions

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

Name of Medication and Dose:	Prescribing Doctor:	Medication Purpose:

Allergies:

Pharmacies

Pharmacy (Pharmacies):

SECTION VII - MEDICAL TRANSPORTATION

DRIVING: Please select the section that best applies to you.

☐ I am able to drive myself to medical appointments.	☐ Someone else drives me to my medical appointments. Driver Name:
☐ I rely on public transportation to attend my medical appointments.	☐ I do not have any form of transportation to attend my medical appointments.

Transportation Logistics

Do you need assistance covering the costs of transportation to medical appointments?	☐ Yes	☐ No
Is any program paying for or assisting with transportation to your medical appointments?	☐ Yes	☐ No
If yes, what program is providing assistance:		
If you need a vehicle with a wheelchair lift, do you have access to one?	☐ Yes	☐ No
Do you have concerns about falling when you go from one place to another?	☐ Yes	☐ No

Section VIII - HOUSEHOLD AND EXPENSES

Household Members

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

Living Arrangement of Applicant:

☐ House ☐ Duplex ☐ Apartment ☐ Mobile Home ☐ Senior Housing
☐ Assisted Living

Residence is:
☐ Owned ☐ Rented ☐ Other:

Property Value (for owned homes):

☐ 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:
Resides at the same address as the applicant: ☐ Yes ☐ No

Military Information

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

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

Name of Person in the Military or Spouse or Child of a Veteran:	Person is a:
	☐ Veteran ☐ Spouse of a Veteran ☐ Active ☐ Child of a Veteran (18 or Younger) ☐ Reserve
	☐ Veteran ☐ Spouse of a Veteran ☐ Active ☐ Child of a Veteran (18 or Younger) ☐ Reserve
	☐ Veteran ☐ Spouse of a Veteran ☐ Active ☐ Child of a Veteran (18 or Younger) ☐ Reserve
	☐ Veteran ☐ Spouse of a Veteran ☐ Active ☐ Child of a Veteran (18 or Younger) ☐ Reserve

Unreimbursed Out Of Pocket Expenses Related To Your Disability

List expenses paid by the 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 the expense of other family members. Supporting documentation is required. Note: A minimum of three months of 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:

SECTION IX - ECONOMIC SUFFICIENCY/FINANCIAL ELIGIBILITY INFORMATION*

Income

Single adults (19 years of age or older with no minor children) should list only their income. Families should list the income of married couples or the income of the adults, including wages of children ages 14 - 18.

Gross (before deductions) Monthly Income: $

Sources (Check for any that apply, then list on next page):

- ☐ 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

Check for each Financial asset readilt available, then list below:

- ☐ Annuities
- ☐ Education Savings Account(s)
- ☐ Mutual Funds
- ☐ Savings Account(s)
- ☐ 401(K)/IRA
- ☐ 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

Include or list below 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 an additional sheet if needed.

Source:	Type:	Value:

***Attach the following documents to Application/Assessment:**

- Copy of your most recent Social Security Award letter
- Verification of earned income (wages/farming income/self-employment income/rental property income/land lease income/pension-retirement-railroad)
- Proof of interest and dividends of savings/investments/annuities
- Verification of unearned income (Social Security disability or retirement benefits/alimony/child support/veterans disability benefits/unemployment insurance/trust fund) and resources
- Verification of cash value of life insurance policies
- Verification of disability-related expenses

Do you have a burial fund?*
☐ Yes ☐ No If so, is it irrevocable? ☐ Yes ☐ No Current Cash Value: $

Beneficiary Name(s), Relationship (Primary):	Beneficiary Name(s), Relationship (Secondary):
Do you have burial insurance? ☐ Yes ☐ No Policy value: $	**Do you own a burial plot?** ☐ Yes ☐ No Plot value: $

*Submit documentation of these assets.

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SECTION X - RELEASE/AGREEMENT AND SIGNATURE

The Disabled Persons and Family Support (DPFS) program adheres to regulations outlined in Title 472 NAC. 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:**

Person Assisting with Application/Assesment (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 Developmental Disabilities
   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- 9188

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Instructions

Instructions for completing Form DPF-3 Revised 11/2024, "Disabled Persons and Family Support Program (DPFS) Service and Device Application – Self Assessment"

Use: Form DPF-3 Revised 11/2024 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 the 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 Regulations reference 472 NAC Chapter 1 through Chapter 3.

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 I: 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, and email address (indicate if contact via email is allowed), name of primary caregiver and indicate if primary caregiver lives with the applicant. Select marital status, ethnicity, immigration status for qualified aliens, and languages spoken.

Section II - FUNCTIONAL ASSESSMENT: This information is used to support the need for specific program services. Check the box for each activity that best describes the level of help the applicant needs for each process if assistance is necessary.

Section III - ASSISTIVE EQUIPMENT: This information is used to support the need for specific program services. Reference the list of potential assistive equipment and list what items are being used.

Section IV - MEDICAL PROVIDER AND INSURANCE: List primary care medical providers, specialists, dentists, and in-home care providers. Check "yes" or "no" to indicate if hospice care is being used. Notate health insurance providers and disability-related expenses not covered by insurance. This information is used to identify needs the DPFS program may supplement.

Section V - PRIMARY CAREGIVER: Complete questions asked about caregiver, including their employment status, hours spent caregiving, any need for caregiver respite, and problems facing the caregiver in delivering care. This section is only necessary if a caregiver is living in the household with the applicant.

Section VI - PRESCRIPTION MEDICATIONS: Indicate whether or not the applicant currently takes prescription medications. If yes, select a response to specify how the cost of medication is paid. List prescriptions, allergies, and pharmacies.

Section VII - MEDICAL TRANSPORTATION: Select the option that best applies to the applicant, indicating the mode of transportation available to attend medical appointments. Choose "yes" or "no" for the supplemental questions, and enter the name of programs outside of DPFS that provide/support medical transportation for the applicant.

Section VIII - HOUSEHOLD AND EXPENSES: List individuals living in the applicant's household, including name, relationship, and dates of birth. This information is used to determine program eligibility. Select the option the best describes the type of live-in arrangement of the applicant and household members. Indicate whether a relative is currently receiving assistance through the DPFS program. Note if you are a veteran or the spouse of a veteran, and list the names and veteran statuses of veterans in the household.

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. Do not include medical or household costs unrelated 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. The information listed here considers whether an expense may be disregarded from the income.

Section IX - 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.

Burial Insurance: Check if you have burial insurance and indicate the value of the policy.

Burial Plot: Check if you have a burial plot and indicate the value of the plot.

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

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

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