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

Division of Medicaid & Long Term-Care

Application for Nebraska Medicaid for Aged and Disabled

This form is used by:

- Those over age 65
- Those under age 65 who are disabled and/or applying for a disability determination
- Aged, Blind, or Disabled (AABD) applying for a state supplemental grant payment

Complete this form and deliver to the local Department of Health and Human Services office or mail to:
DHHS, Medicaid Eligibility Program
PO Box 2992
Omaha, NE 68103-2992
or Fax the application to: **(402) 742-2351**

Contact the Department at (855) 632-7633 if assistance is needed in completing this application.

Email Address:

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

☐ **Text Messaging:** By checking 'this box', I agree to receive text messages on the cell phone number above from DHHS regarding my benefits. These benefits include; Medicaid, CHIP, SNAP, ADC, LIHEAP, CC Subsidy, AABD payment and SSAD. I agree to contact DHHS if my cell phone number changes or if this number is no longer in my possession. I understand that I can opt out of this in the future by contacting DHHS. *NOTE: Text messaging is currently under development and is targeted to be available in the near future.*

1. If you need us to provide an interpreter, check here: ☐ Which language?_____

2. Do you or anyone in your household need help with any of the following? Please mark all you wish to apply for:

☐ Medicaid ☐ Personal Assistance Services ☐ Program for All Inclusive Care for Elderly (PACE) ☐ Aged and Disabled Waiver ☐ AABD Grant

3. Complete this section for yourself and everyone who lives with you, even if they are not applying. If you are residing in a nursing home, boarding home or other group home, list only yourself, and your spouse. Depending on the type of assistance you have requested, immigration status and Social Security Numbers (SSNs) may be verified. Attach another sheet if more space is needed.

Name List yourself First Last, First	Relationship to you. If not related write "NR"	Birthdate	Age	Sex Male (M) Female (F)	Social Security Number	Is this person a U.S. Citizen?		Is this person disabled?		Marital Status & Effective Date
						Yes	No	Yes	No	
	SELF									

4. Household Street Address: (Include Street, City, State, Zip Code)	Telephone Number:
Mailing Address: (If different from Household Street Address)	Other Phone Number:

5. List any previous names used including maiden name:

6. Please mark your living arrangement:

- ☐ Live in a house - rent/own/mortgage
- ☐ Rent an apartment, duplex, triplex
- ☐ Rent a room
- ☐ Board and room situation
- ☐ Adult Family Home
- ☐ Center for Developmentally Disabled
- ☐ Assisted Living
- ☐ Nursing home
- ☐ Drug abuse or alcohol treatment center
- ☐ Other _____

7. Mark **Yes** or **No** and the amount your household is currently billed for each of the following:

Expense	Answer Yes or No for each line		Amount	Who pays this bill? (List names of anyone who helps pay this bill)	How often paid?
a. Rent	☐ Yes	☐ No			
b. Mortgage	☐ Yes	☐ No			
c. Lot Rent	☐ Yes	☐ No			
d. Property taxes on home (if not included in mortgage)	☐ Yes	☐ No			
e. Homeowners insurance (if not included in mortgage)	☐ Yes	☐ No			
f. Condominium/ Association fees	☐ Yes	☐ No			
g. Other: _____ _____	☐ Yes	☐ No			

8. **OPTIONAL:** Indicate the race and ethnic category of the head of household. 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 that benefits are distributed without regard to race, color, ethnicity, or national origin.

RACE: Select all that apply:

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Other _____

ETHNIC CATEGORY: Are you Hispanic or Latino? ☐ Yes ☐ No

9. Do you or anyone in your household owe medical bills from the past three months? ☐ Yes ☐ No

If **yes**, give us the following information:

Name	Date of Service	Name	Date of Service

10. Does anyone in your household have Medicare coverage? ☐ Yes ☐ No

If **yes**, complete the following:

Person's Name	Medicare Claim #	Person's Name	Medicare Claim #

11. Is anyone in your household covered by personal or employer-provided health insurance, Public Health Service, TRI-CARE, CHAMPUS, VA, Medical Coverage as a retirement benefit, or Medicare Supplement?

☐ Yes ☐ No If **yes**, complete the following:

Names of Insured Persons and Policy Holder	Insurance Company Name, Address, Phone Number	Policy/Group Number	Cost Per Month

A. INCOME

12. Do you or does anyone in your household work? Work includes employment and self-employment. Self-employment could be farming, odd jobs, providing child care, housekeeping, etc.

Does any Adult or Child Currently Receive any Money from:	Yes	No	If Yes, Who is it?	Employer Name or Income Source:	Gross Amount: (before deductions)	How often Paid?	Hourly Rate:
Salaries, Wages, Tips, Commissions, etc., (Provide pay stubs for each adult)	☐	☐		Business Name: Address: Date Started:			
Salaries, Wages, Tips, Commissions, etc., (Provide pay stubs for each adult)	☐	☐		Business Name: Address: Date Started:			
Self-Employment Income (Include your most recent Federal Tax Return with 1040 and all schedules)	☐	☐		Business Name: Address: Date Started:			

NOTE: You are allowed to claim certain costs of doing business (expenses) to apply against your self-employment income. These costs can be obtained from tax returns or self-employment ledgers. DHHS will explain which of these documents (tax returns or ledgers) you will need to provide to identify the allowable costs of doing business.

13. Has anyone in the household left employment in the last 90 days? ☐ Yes ☐ No

If **yes**, complete the following:

Name	Employer Information	Date of Change (month, day, year)	Reason Job Ended
	Name: Address:		☐ Laid Off ☐ Quit ☐ On Strike ☐ Resigned ☐ Terminated
	Name: Address:		☐ Laid Off ☐ Quit ☐ On Strike ☐ Resigned ☐ Terminated

B. OTHER INCOME

14. Have you or anyone in your household applied for or is anyone in your household receiving other income that is not from working?

☐ Yes ☐ No

If **yes**, give us the following information:

- Write the monthly amount received and who receives it below.
- If anyone has applied to receive these benefits, but does not receive them yet, write "Applied" on the line.
- If left blank, no amount is listed or "Applied" is not written in, this means no one receives nor plans to receive this income.

Attach another sheet of paper if more space is needed.

SSI $ _____ Civil Service $ _____

Social Security $ _____ Interest/Dividend $ _____

Pension/Retirement $ _____ Railroad Retirement $ _____

Veterans Benefits $ _____ Military Allotment $ _____

Cash Assistance Payments $ _____ Rental Income $ _____

Workers' Compensation $ _____ Claims/Disability $ _____

Unemployment Compensation $ _____ Insurance/Accident Settlement $ _____

Child Support/Alimony $ _____ Child Support/Alimony $ _____

Farm Income $ _____ Striker Income $ _____

Annuities $ _____ Life Estates $ _____

Trusts/Inheritances $ _____ Partnerships/Corporations $ _____

Native American Benefits $ _____ Prizes/Awards/Winnings/Lottery $ _____

Gifts/Money from Relatives or Friends $ _____ Contributions $ _____

15. Do you or anyone living in your household have any of the following resources? This includes resources on which your name or any household member's name appears as an owner.
Answer **Yes** or **No** for each line:

Type of Resources	Answer yes or no	Amount	Owned by	Account Number	Where Located
a. Cash	☐ **Yes** ☐ **No**		1.	1.	1.
			2.	2.	2.
b. Checking	☐ **Yes** ☐ **No**		1.	1.	1.
			2.	2.	2.
c. Savings	☐ **Yes** ☐ **No**		1.	1.	1.
			2.	2.	2.
d. Real Estate/Real Property/Farm Land	☐ **Yes** ☐ **No**		1.	1.	1.
			2.	2.	2.
e. Trusts	☐ **Yes** ☐ **No**		1.	1.	1.
			2.	2.	2.
f. Life Insurance	☐ **Yes** ☐ **No**		1.	1.	1.
			2.	2.	2.
i. Burial Funds/ Trusts/Burial Spaces	☐ **Yes** ☐ **No**		1.	1.	1.
			2.	2.	2.
j. Nursing Home Account	☐ **Yes** ☐ **No**		1.	1.	1.
			2.	2.	2.

16. Do you or or anyone living in your household have any of the following resources? This includes resources on which your name or any household member's name appears as an owner.

☐ Yes ☐ No

If **yes**, write the value on the line provided.

$ _____ 401K

$ _____ Annuities

$ _____ Certificates of Deposit

$ _____ Credit Union Accounts

$ _____ Crops/Livestock

$ _____ IRA

$ _____ Keogh

$ _____ Machinery

$ _____ Savings Bonds

$ _____ Stocks/Investments

$ _____ Other: _____

17. Does your name or any household member's name appear on the title of any licensed or unlicensed vehicles (include cars, trucks, motorcycles, ATVs, boats, RVs, snowmobiles, trailers, aircraft, etc.)?

☐ Yes ☐ No

If **yes**, give us the following information:

Owner	Type of Vehicle	Model	Year	Value	Amount Owed
				$	$
				$	$

18. Have you or anyone in your household sold, traded or given away anything of substantial value within the past 60 months (5 years)?

☐ Yes ☐ No

If **yes**, give us the following information:

Owner	Type of Vehicle	When	Value
			$

WHEN THIS APPLICATION IS SIGNED I AGREE THAT

Under penalties of law and/or perjury, I declare I have read this application, including accompanying statements and to the best of my knowledge, the information is true, correct and complete. I understand my responsibilities and agree to fulfill them. I understand I may have to provide proof of what I have said. If written proof is not available, I agree to give the applicable name or organization so that the local office may obtain the necessary proof. I will cooperate fully with state and federal personnel in a Quality Control Review. I certify all persons for whom assistance is being requested are U.S. citizens or are in satisfactory immigration status according to the program(s) or services requested. I authorize the release of the SSNs provided on this application to DHHS to use for the purposes mentioned in your information packet.

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the Nebraska Department of Health and Human Services and its agents to request from third parties any information or documents necessary for the administration of its programs. Such third parties shall include, but not be limited to: the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, a consumer reporting agency, and financial institutions. Any third party shall also be authorized to provide any information or documents requested by the Nebraska Department of Health and Human Services concerning myself or, when required by law, any other person. I further authorize the Nebraska Department of Health and Human Services to release such information or documents to cooperating State or Federal Agencies in accordance with any applicable law.

This authorization is given only to the Nebraska Department of Health and Human Services to be used in the administration of its programs and for no other purposes. It shall continue in effect until the earliest of: the rendering of a final adverse decision on my application for medical assistance, the cessation of my eligibility for medical assistance, or such time as I state in writing that I rescind this authorization.

I release any third party from any and all liability to me and, when applicable, any other person, for supplying the aforementioned information or documents.

Third Party Liability: Individuals who receive Medical Assistance (Medicaid) 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 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 at 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 person. 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 Medicaid 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 services for a Medicaid recipient, 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 Medicaid 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.

Medicaid:

- Present proof of your current Medicaid 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 cost 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 your coverage is Nebraska Medicaid.

Failure to follow certain conditions may result in your personal responsibility to pay the bills.

Annuity Requirement:
As a condition of receiving medical assistance coverage for long-term care services for you or your spouse, DHHS must become the remainder beneficiary of any annuity under standards prescribed by the U.S. Secretary of Health and Human Services.

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 and request the "Medicaid Estate Recovery" program brochure.

A reproduction of this release is as valid as the original.

_____	_____
Signature of Applicant Date	Signature of Person Who Helped - Authorized Representative/ Guardian/Conservator/Power of Attorney
_____	COMPLETE THE FOLLOWING IF GUARDIAN/
CONSERVATOR/ Printed Name (if Applicant signs with a mark) Date	POWER OF ATTORNEY
_____	_____
Signature of Witness (if a mark was used) Date	Name of Guardian/Conservator/Power of Attorney
_____	_____
Signature of Other Adult Household Member Date	Address and Phone Number of Guardian/Conservator/ Power of Attorney
	Does Guardian/Conservator receive payment for services? ☐ Yes ☐ No

I hereby authorize the Nebraska Department of Health and Human Services and its agents to request from third parties any information or documents necessary for the administration its programs, including financial information. I also authorize the release of my Social Security Number for this purpose.

_____
Signature of Spouse of Applicant Date

Mail Completed Application

Mail your signed application to:

Nebraska Department of Health and Human Services
Medicaid Eligibility Program
PO Box 2992
Omaha, NE 68103-2992

Voter Registration (Optional)

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 ANSWER ABOVE, 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 Medicaid 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 helps 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 of Nebraska
State Capitol Building
P.O Box 94608
Lincoln, NE 68509-4608
Telephone (402) 471-2555

Need Help With Your Application?

? **NEED HELP WITH YOUR APPLICATION?** Visit **ACCESSNebraska.ne.gov** or call us at **1-855-632-7633** or **(402) 473-7000** in Lincoln or **(402) 595-1178** in Omaha. Para obtener una copia de este formulario en Español, llamé **1-855-632-7633**. If you need help in a language other than English, call **1-855-632-7633** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **(402) 471-7256**.

YOU HAVE THE RIGHT TO:

- Apply and discuss any action taken on your application or case with a worker or a worker's 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.
- Have your information treated confidentially.

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 a worker.
- Pay a co-pay for certain medical services if required to do so.
- Cooperate with state and federal personnel in a Quality Control review.
- Cooperate with Nebraska Managed Care Program for certain Medicaid recipients.
- Ask questions if you do not understand something about any program requirements.

FAIR HEARINGS

If you disagree with any action taken by DHHS that affects your benefits, you may request a fair hearing in writing or orally through the local office. You may continue to receive your current level of assistance until a hearing decision is made IF you request a hearing within 10 days from the date of the agency notice. 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.

CIVIL RIGHTS

In accordance with Federal law and U.S. Department of Health and Human Services (HHS) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. Under the Food Stamp Act and USDA policy, discrimination is prohibited also on the basis of religion or political belief.

To file a complaint of discrimination, contact USDA or HHS. Write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, S.W., Washington, D.C., 20250-9410 or call (202) 720-5964 (voice and TDD). Write HHS Director, Office for Civil Rights, Room 506-F, 200 Independence Avenue, S.W., Washington, D.C., 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TTY). USDA and HHHS are equal opportunity providers and employers.

VOTER REGISTRATION

Any citizen in the State of Nebraska who has met the voter registration requirements and applies for Medicaid 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 helps 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 of Nebraska
State Capitol Building
P.O Box 94608
Lincoln, NE 68509-4608
Telephone (402) 471-2555

REPORTING CHANGES FOR MEDICAID

Report all changes within 10 days to your worker such as:

- Changes in the household - someone moves in or out
- If you move
- New employment
- Termination or change of employment - including job training or other work activities
- Change in the amount of monthly income
- Changes in disability or incapacity
- A change in health insurance
- A change in a resource

SOCIAL SECURITY NUMBER

DHHS asks for Social Security Numbers (SSNs) of all individuals for whom assistance is requested as required by the federal Social Security law. 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 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. 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 (Birth & Death)
  - Nebraska DHHS
- Unemployment Compensation
  - Nebraska Department of Labor - Employment
- Employment
  - Nebraska Department of Labor
  - Social Security Administration
  - Nebraska DHHS
- Child Support
  - Clerk of the District Court
  - Child Support Payment Center
- Resources and Income
  - Internal Revenue Service
- Social Security Benefits (RSDI)
- Supplemental Security Income (SSI)
  - Veterans' Benefits
  - 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. Fraudulent participation may result in criminal or civil action or administrative claims.

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DEPT. OF HEALTH AND HUMAN SERVICES

Notice of Information Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you may access this information. Please review it carefully.

Effective:04/14/2003

The Department of Health and Human Services of the State of Nebraska, and those Agencies inclusive of health care facilities and medical assistance programs that are affiliated under the common control of the Nebraska Partnership for 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 for purposes of :

- **Treatment:** We may use your medical information to provide you with medical treatment or services. For example, a doctor may need to tell the dietitian if you have diabetes so that appropriate meals can be prepared.
- **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 that the hospital can be reimbursed.
- **Operations:** We may use and disclose medical information about you for medical 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:

- **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 to a person or company 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:** Consistent with applicable federal and state laws, 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.
- **Military Activity and National Security:** When the appropriate conditions apply, we may use or disclose Protected Health Information of individuals who are Armed Forces personnel.
- **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: Under the law, 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.

OTHER USES OF MEDICAL INFORMATION

You can provide us written authorization to use your medical information for other purposes; you may revoke that permission, in writing, at any time.

THIS NOTICE IS AVAILABLE IN LARGER PRINT AND WITH DETAILED EXPLANATION UPON REQUEST.

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DHHS, HIPAA Privacy and Security Office, 301 Centennial Mall South, 3rd Floor, P.O. Box 95026, Lincoln, NE 68509-5026

YOUR RIGHTS TO PRIVACY:

❖ **Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records but does not include psychotherapy notes. To inspect and copy your medical information, you must submit your request in writing at the Site of Service, or to the State of Nebraska, Department of Health and Human Services, HIPAA Privacy and Security Office at the address on the top of this Notice. If you request a copy of information, we may charge a fee for the cost of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request the denial be reviewed. For more information call **(402) 471-8417.**

❖ **Right to Amend.** If you feel that medical information about you is incorrect or incomplete, you may ask us to amend 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 State of Nebraska, Department of Health and Human Services, HIPAA Privacy and 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 an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list, you must submit your request in writing at the Site of Service, or to the State of Nebraska, Department of Health and Human Services, HIPAA Privacy and Security Office address on the top of this Notice. 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: for example, on paper, or by e-mail.

❖ **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, or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you can ask that we not use or disclose information about a surgery you had performed.

❖ **We are not required to agree to your request for restrictions.** 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 State of Nebraska, Department of Health and Human Services, HIPAA Privacy and Security Office at the address on the top of this Notice. 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; for example, disclosures to your spouse.

❖ **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. For example you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing at the Site of Service, or to the State of Nebraska, Department of Health and Human Services, HIPAA Privacy and Security Office. Your request must specify how or where you wish to be contacted.

How to file a complaint about your privacy rights

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 our Privacy Contact, **DHHS HIPAA Privacy and Security Office** at **(402) 471-8417** Monday through Friday from 9:00 a.m. to 4:30 p.m., except State holidays, or dhhs.HIPAAOffice@nebraska.gov for further information about the complaint process. 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). You will not be penalized for filing a complaint.**

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.

Contact Information

This notice fulfills the "Notice" requirements of the Health Information 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 the State of Nebraska, Department of Health and Human Services please direct them to: The HIPAA Privacy and Security Office, 301 Centennial Mall South, Lincoln, Nebraska 68509-5026. By e-mail to dhhs.HIPAAOffice@nebraska.gov .

THIS NOTICE IS AVAILABLE IN LARGER PRINT AND WITH DETAILED EXPLANATION UPON REQUEST.