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

Nebraska Department of Health and Human Services

Application for Home and Community Based Service (HCBS) Waiver

This application is for all Home and Community Based Service (HCBS) Waivers. The person needing services is the applicant. Let us know if assistance or an alternative format is needed. You can reach out to 877-667-6266 for questions.
Please select the HCBS waiver you are applying for:

- ☐ Intellectual or Developmental Disabilities (ID/DD)
- ☐ Aged and Disabled (AD)
- ☐ Traumatic Brain Injury (TBI)

1. ☐ I am applying for Intellectual or Developmental Disability Waiver
   Do you have an intellectual or developmental disability?
   ☐ Yes ☐ No
   Did your intellectual or developmental disability occur before the age of 22?
   ☐ Yes ☐ No

2. ☐ I am applying for the Aged and Disabled Waiver
   I am currently living in:
   ☐ Assisted Living ☐ Private Residence ☐ Nursing Home ☐ Hospital ☐ Homeless
   I would like to receive AD Waiver services:
   ☐ Assisted Living ☐ Private Residence

3. ☐ I am applying for the Traumatic Brain Injury Waiver
   Do you have a traumatic brain injury?
   ☐ Yes ☐ No
   Did the injury occur after birth and is not hereditary, congenital or degenerative?
   ☐ Yes ☐ No

SECTION 1: Applicant

1. First Name	Middle Initial	Last Name	Ext.

2. List any previous names used, including maiden name, if applicable:

3. Birthdate	SSN	Phone (include area code)	Gender

4. Address	City	State	Zip
5. Mailing Address	City	State	Zip

6. Email

7. Preferred Language

8. Have you or a family member ever served in the military?
   ☐ Yes ☐ No
   If yes, name: _____

9. Signature

10. Relationship to Applicant	Date

Please complete Section 2 OR Section 3 OR Section 4 (just ONE section)

SECTION 2: Authorized Representative

I am 19 or older and I authorize the following representative (e.g. parent, friend, advocacy organization) to provide assistance and consent for release of information. (The Authorization for the Disclosure of Protected Health Information MUST be filled out.)

Representative

Relationship to Applicant		Phone (include area code)
Address	City	Zip

SECTION 3: Guardianship/Attorney in Fact

1. I am 19 or older and have a court-appointed guardian or Attorney in Fact (also known as a Power of Attorney or POA).
   ☐ Yes ☐ No

2. Name of Guardian or Attorney in Fact		Phone (include area code)
3. Address	City	Zip

If you have additional guardians, please list information requested above on a separate sheet and attach.

SECTION 4: Parent of a Minor

1. Applicant is a minor child under 19 years old.
   ☐ Yes ☐ No If yes, answer the following:

2. Name of Parent(s)			Phone (include area code)
3. Address	City	State	Zip

Please complete Section 5 and 6

SECTION 5: Foster Care

1. Applicant is or has been a child in the legal custody of the Nebraska Department of Health and Human Services.
   ☐ Yes ☐ No

If in foster care now, name of CFS or CFOM Worker	Phone (include area code)
2. If applicable, name of NFC caseworker	Phone (include area code)

SECTION 6: Citizenship/Residency

1. I am a United States Citizen
   ☐ Yes ☐ No

2. Place of Birth: City	State	Country

3. I am a qualified alien under the Federal Immigration & Nationality Act
   ☐ Yes ☐ No

4. Alien Number	Immigration Status

5. I am a legal resident of Nebraska
   ☐ Yes ☐ No

SECTION 7 (optional): Additional Information

If there is any other information relevant to this application that you want us to know, note it here. *If none, proceed to the next section.*

SECTION 8 (optional): Voter Registration

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

Please complete Section 9

SECTION 9: Records

Please submit the following records with this application, or provide names and contact information so that DDD may gather the information.

☐ I agree to allow my information to be used and retrieved from data sources for this application.

Please list additional school or medical contact information on a separate sheet and attach.

1. Educational reports (i.e. Multi-Disciplinary Team (MDT) reports for the last ten years.

2. School		Address	
City	State	Zip	Phone (include area code)

3. Related physician reports/diagnoses (i.e., medical, genetic syndrome/disorder) with current prescribed medications (include purpose of medication, dosage, and frequency of administration).

Specific disability

4. Medical Practitioner

Address

City	State	Zip	Phone (include area code)

5. Reports from licensed psychologist for the last five years.
   ☐ None available

6. Psychologist

Address

City	State	Zip	Phone (include area code)

7. Reports from psychiatrist and therapist/counselor for the last five years.
   ☐ None available

8. Psychiatrist

Address

City	State	Zip	Phone (include area code)

9. Therapist or Counselor

Address

City	State	Zip	Phone (include area code)

10. Copy of court-appointed guardianship papers (if applicant is 19 years or older and has a court-appointed guardian).

Please submit the application and records to:

DD Applications
Division of Developmental Disabilities
Nebraska Department of Health and Human Services
301 Centennial Mall South
P.O. Box 98947
Lincoln, NE 68509-8947
or Fax: (402) 328-6243
or E-Fax: DHHS.DDGoldsefax@nebraska.gov
or Email to: DHHS.DDEligibility@nebraska.gov

AD Applications (AD/TBI)
Division of Developmental Disabilities
Nebraska Department of Health and Human Services
301 Centennial Mall South
P.O. Box 98947
Lincoln, NE 68509-8947
or Fax: (402) 328-6257
or Email to: DHHS.ADwaiverApp@nebraska.gov

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Authorization for the Disclosure of Protected Health Information

Failure to sign this form will not affect treatment, or payment, however it may affect enrollment, or eligibility for certain benefits, provided per Nebraska Department of Health and Human Services. I understand the advantages and disadvantages and freely and voluntarily give permission to release specific information about me. I also understand that I am not required to disclose my social security number, though disclosure may make it easier or quicker for information to be provided.

Name (Last, First, M.I.)		Date of Birth
Social Security Number	Case/Chart # (if known)	Period Covered
Information will be disclosed to: (Name, Address, City, State, Zip) Division of Developmental Disabilities Nebraska Department of Health and Human Services 301 Centennial Mall South PO Box 98947, Lincoln, NE 68509-8947 Or Fax: (402) 328-6243 or E-Fax: DHHS.DDGoldsefax@nebraska.gov or Email to: DHHS.DDEligibility@nebraska.gov The information to be released pursuant to this authorization is limited to records/ information from or in possession of applicable parties.		Reason for Disclosure: X Eligibility Determination X My Request ☐ Insurance Claim ☐ Legal Purposes ☐ Consultation and/or Treatment Planning ☐ Other (be specific): _____

Specific Information to be disclosed:

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- ☐ All information that can be disclosed relating above individual to the Adult Abuse and Neglect Central Registry and the Child Abuse and Neglect Central Registry.
- ☐ Aftercare Referral Form
- ☐ Discharge Summary
- ☐ Diagnosis
- ☐ History & Physical Examination
- ☐ Laboratory
- ☐ Medications
- ☐ Progress Notes
- ☐ Psychiatric History & Treatment
- ☐ All other non-medical information, records, or documents relating to above individual which could be released.
- ☐ Psychological Evaluation & Treatment
- ☐ Social History
- ☐ X-rays & Other Diagnostic Imaging Results
- ☐ Alcohol and/or Drug Abuse Treatment
- ☐ Genetic Testing Information
- ☐ HIV/AIDS Information
- ☐ Sickle Cell Anemia
- ☐ Other (be specific):
  _____

This Authorization (unless revoked earlier in writing) shall terminate on _____ (must have date or event filled in). By Signing this authorization, I acknowledge that the information to be released may include material that is protected by Federal or State law, including benefit or enrollment information; protected health information that may include Drug/Alcohol, HIV, or sickle cell anemia related information. My signature authorizes release of all this information. I also understand this authorization may be revoked at any time by submitting a written request in accordance with the then current DHHS Notice of Privacy Practices (if to DHHS), or by submitting a written request to the health care provider or entity, or otherwise, and it will be honored with the exception of information that has already been released. I also understand if the recipient of the information is not a health plan or health care provider, the information may no longer be protected by privacy laws.

Client's Signature	Date
Guardian Signature (if applicable)	Date

NOTICE TO RECIPIENT

This information has been disclosed to you from records whose confidentiality is protected by state and federal laws (including Federal Regulations, 38 CFR 1.460-1.499, 42 CFR Part 2 and Part 431, Subpart F) which prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug patient. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

☐ I understand that failure to fulfill the below obligations may result in denial or termination of funding for Home and Community Based Services.

Notice of Rights

As a person who has requested developmental disabilities services, I understand that I have the following rights:

- The right to receive written notice of any decision, any termination, or change of previously authorized services.
- The right to file an appeal in writing of any decision or action and to have a fair hearing on my appeal. I understand that I must appeal within 90 days of the date of any Notice of Decision that I receive.

Notice of Obligations

When funding is allocated, I understand and agree to the following obligations:

- I must apply for and accept all benefits that I may be eligible to receive, which may include SSI, SSA, Nebraska Medicaid, and Home & Community Based waiver services. I agree to take action to maintain eligibility for all benefits that I may be eligible to receive.
- I must pay the amount of my Medicaid share of cost obligation to my provider monthly when I am informed of the obligation.
- I must complete and submit required information prior to starting funded services, annually, or as requested. This may include benefit and resource information or a copy of my tax returns for the determination of my ability to pay for community-based developmental disabilities services.
- I must participate in any assessments or evaluations required to maintain my services, which include, but are not limited to psychological, annual medical, and dental evaluation(s), as well as the Objective Assessment Process.

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