

<p>Demographics (Optional):</p> <p>Ethnicity:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Not of Hispanic, Latino, or Spanish origin <input type="checkbox"/> Mexican <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Central American <input type="checkbox"/> Cuban <input type="checkbox"/> South American <input type="checkbox"/> Other Hispanic, Latino, or Spanish origin <input type="checkbox"/> Other/Unknown 	<p>Race:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Black/African American <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Asian <input type="checkbox"/> American Indian <input type="checkbox"/> Alaskan Native <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Other/Unknown
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I AGREE TO:

1. Notify the Disabled Children's Program worker before receiving services at scheduled appointments and laboratory tests;
2. Keep all appointments for medical care and medical examinations;
3. Follow the individual medical treatment plan;
4. Notify the Disabled Children's Program worker of emergency care within five working days;
5. Obligate payment for that part of the treatment which has been agreed upon by the Disabled Children's Program and the client or has been determined to be the client's responsibility;
6. Assume responsibility for general health care for the client; and
7. Allow the Department of Health and Human Services to release and obtain any medical information for the purpose of medical treatment.

I believe the information given is true, correct, and complete. I know the penalty for hiding information or giving false information. I certify under penalty of perjury that all answers I give are correct and complete to the best of my knowledge. I understand and agree to provide documentation to prove what I say.

Signature of Parent/Legal Guardian	Signature Date
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Submit applications using one of the following methods:
 Email: DHHS.MHCP@nebraska.gov
 Fax: (402) 328-6219
 Mail: Medically Handicapped Children's Program, PO Box 95026, Lincoln, NE, 68509-5026

WHAT SHOULD I KNOW (Rights and Responsibilities)

PLEASE KEEP THIS FOR YOUR INFORMATION

By completing and signing the Disabled Children's Program application and providing documents required to determine whether I am eligible for respite assistance AND by accepting benefits that I am eligible to receive, I understand the following information and agree to the following requirements.

- I must tell the truth. It is a crime to lie on this application.
- I may have to give papers that show what I have told you is true.
- I may have to tell you of any changes to the information I gave you on my application.
- If I think DHHS made a mistake, I can ask for an appeal or fair hearing.
- DHHS will not discriminate.
- DHHS will confirm citizenship and immigration status for everyone applying for benefits.
- DHHS will take back any benefits you should not have received.
- DHHS will tell you when your benefits will decrease or be terminated.

YOU HAVE THE RIGHT TO

- Apply and discuss any action taken on your application or case with a worker or a 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.
- 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 to you.

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 you may be eligible to receive.
- Complete and submit required information prior to eligibility determination initially, annually, or as requested. This may include a copy of my tax returns or resource verification.
- Ask questions if you do not understand something about program eligibility.

RIGHT TO APPEAL

You have the right to appeal for a hearing on any action or inaction of any state employee or official with regard to application for or receipt of services. You may appeal because your application for services is denied or is not acted upon with a reasonable promptness; or your services are suspended, reduced, discontinued or terminated.

You (or your representative) have 90 days following the date the notice of action is mailed to request a fair hearing.

In cases of intended adverse action where DHHS is required to send you timely and adequate notice, if you request an appeal hearing within ten days following the date the notice of finding is mailed, DHHS shall not carry out the adverse action until a fair hearing decision is rendered. This regulation does not apply to those situations where DHHS may dispense with timely notice and is only required to send you adequate notice.

This regulation in no way restricts DHHS from continuing normal case activities and implementing changes to your case that are not directly related to the appeal issue.

To file an appeal you may contact the assigned worker. DHHS will explain the appeal procedure and assist you in completing the appeal form. The appeal request must be in writing.

Once you've filed the appeal, arrangements for a hearing will be made and you will be notified of the time and place. You may represent yourself at the hearing or be represented by a legal representative of your choosing.

RIGHT TO BE FREE FROM ABUSE, NEGLECT, OR EXPLOITATION

You have the right to be free from situations which may endanger your life, physical health, or mental health. If you believe you are being abused, neglected or exploited, report your concerns to the proper authorities. This may include the Nebraska Hotline for reporting abuse and neglect 1-800-652-1999.

RESPONSIBILITY TO REPORT

You must tell your worker within 10 days if you:

- Move to a new residence; or someone moves in with you; or someone leaves your household.
- Changes in the amount of monthly income.
- Are not treated with dignity and respect by a provider. This includes having your privacy and confidentiality protected and being free from discrimination.

RESPONSIBILITY TO PARTICIPATE IN PROGRAM ELIGIBILITY DETERMINATION

You must provide requested supportive documents to determine eligibility

and authorize respite funding to pay for providers of your choice; and to share information with your worker when your situation changes.