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

Nebraska Department of Health and Human Services
Medically Handicapped Children's Program
APPLICATION

Name of Applicant		Date of Birth	Social Security Number
Parent/Guardian Name		Email Address	
Address		Mailing Address (if different)	
City	State	Zip Code	County
Home Phone	Cell Phone	Work Phone	
School/Grade		Primary Care Physician	
Health Insurance		Physician Specialists	

Household Members (Please print)	**Relationship to Child**
(Please use additional sheet, if needed)	

Please describe your child's disability (diagnosis):

Insurance Company	**Monthly Premium Amount**	**Policy Number or Group Plan Number**	**Type of Coverage (medical, dental, vision, prescription)**	**Who is covered by Policy?**

Financial Information: List the amount of income you receive (your family) from each of the sources below. Single adults (19 years of age or older) should list only YOUR income.

Gross Income (Income before deductions)	**Amount**	**How often received?**	**Who receives it?**	**Employer**
Wages, overtime, bonuses, commission, etc. (Paystubs may be required for verification)				
Self-Employment (Complete copy of Federal IRS 1040 is required).				

Gross Income (Income before deductions)	Amount	How often received?	Who receives it?
Alimony			
Child Support			
Unemployment Compensation			
Workman's Compensation			
Interest (on savings or bonds)			
Dividends (from stockholdings or association memberships)			
Retirement Pensions			
Inheritance, Estates, Trust Funds, etc.,			
Supplemental Security Income (SSI)			
Veteran's Pensions			
Contributions (family support)			
Rental Income			
Net Land Lease Income			
Boarders			
Royalties			
Social Security Retirement			
Maintenance of State or County Ward (including foster care payments)			

EXPENSES:

Child Care Costs for Employment (per month)	Child Support / Alimony Paid (per month)

Tuition / Books Paid Out-of-pocket for 1st Degree (last 12 months)

I AGREE TO:

1. Notify the Medically Handicapped 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 Medically Handicapped 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 Medically Handicapped 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 Applicant, Representative or Parent / Legal Guardian	Date