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

Nebraska Department of Health and Human Services

Genetically Handicapped Persons Program Application

Do you need an interpreter? ☐ Yes ☐ No If yes, what language do you speak?

Name of Applicant	Date of Birth	Gender ☐ Male ☐ Female	Social Security Number
Please check the diagnosis below: ☐ Cystic Fibrosis ☐ Hemophilia ☐ Sickle Cell Disease			

Applicant Citizenship Status: ☐ A Citizen of the United States OR ☐ I am a qualified alien under the federal immigration and Nationality Act
Immigration Status and Alien Number:

Address	Email Address (Elect to receive email correspondence) ☐ Yes ☐ No		
City	State	Zip	County
Mailing Address (if different from above)	City/State/Zip		
Home Phone	Cell Phone	Work Phone	
Primary Care Physician	Health Insurance		
Physician Specialists			

Household Members	Date of Birth	Gender	Relationship to Applicant

(Please use additional sheet, if needed)

Insurance Company	Monthly Premium Amount	Policy Number or Group Plan Number	Who is covered by Policy?

Financial Information: List the amount of income you receive (your family) from each of these sources below.

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)	

Demographics (Optional):

Ethnicity:
- ☐ Not of Hispanic, Latino, or Spanish origin
- ☐ Mexican
- ☐ Puerto Rican
- ☐ Central American
- ☐ Cuban
- ☐ South American
- ☐ Other Hispanic, Latino, or Spanish origin
- ☐ Other/Unknown

Race:
- ☐ Black/African American
- ☐ White/Caucasian
- ☐ Asian
- ☐ American Indian
- ☐ Alaskan Native
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ Other/Unknown

I AGREE TO:

1. Notify the Genetically Handicapped Persons 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 Genetically Handicapped Persons 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 Genetically Handicapped Persons 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 Legal Guardian	Date

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

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WHAT SHOULD I KNOW

(Rights and Responsibilities)

PLEASE KEEP THIS FOR YOUR INFORMATION

By completing and signing the Genetically Handicapped Persons 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 under- stand 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.