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

Department of Health and Human Services
MEDICAL DEDUCTIONS WORKSHEET
Medically Handicapped Children's Program
Genetically Handicapped Person's Program

Return completed form to:
DHHS.MHCP@nebraska.gov
OR
Fax: (402) 328-6219

Client Name	Date of Birth

Please itemize all dental and medical expenses/medical equipment/home modifications/medical transportation/lodging for the last 12 months for the entire family. Attach an additional sheet if more entries are necessary. DO NOT ATTACH BILLS.
Include insurance premiums paid in the last 12 months.

Family Member Who Received the Care	Physician, Hospital, Dentist, etc. Who Provided the Care	Date of Service	Total Bill	Amount Paid by Insurance	Amount Paid by Family	Amount Owed
TOTAL						

I attest the above information is accurate and complete. I agree to provide documentation upon request.

Signature of Applicant, Representative or Parent/Legal Guardian	Date