NEBRASKA
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DEPT. OF HEALTH AND HUMAN SERVICES

Nebraska Department of Health and Human Services
Heritage Health Adult

Chronically Homeless Attestation Form

Purpose of Providing Attestation Form Information:
Nebraska DHHS MLTC uses this Attestation form to determine if the Heritage Health Adult Medicaid Expansion beneficiary is Chronically Homeless. Beneficiaries who are determined Medically Frail due to Chronically Homelessness by DHHS will be enrolled in the HHA Prime benefit tier. Determinations for Medically Frail due to Chronically Homelessness are effective for 12-months before a redetermination is required.

Provider Instructions:
If you are a provider of homeless services or a government funded homeless program, and have a Medicaid beneficiary that you believe meets the Chronically Homeless criteria, as defined in the categories below, please complete this form. Incomplete forms will not be accepted.

Upload form to: http://dhhs.ne.gov/pages/accessnebraska.aspx

If you do not have internet access or if you have questions mail or E-mail form to:

Nebraska DHHS
ATTN: Heritage Health Adult Medically Frail Determinations
PO Box 95026
Lincoln, NE 68509
E-Mail: dhhs.medfrailreview@nebraska.gov

Beneficiary Information

Date Assessment Completed:	Medicaid ID (if available):
Medicaid Beneficiary's Name (Last, First, Middle Initial):	
Address (Optional):	
City, State, Zip Code (Optional):	Date of Birth:

Chronic Homelessness

Beneficiary Meets the Following Criteria	Yes / No
1. Has been continuously homeless for a year or more, (HUD defines "homeless" is defined as "a person sleeping in a place not meant for human habitation (e.g. living on the streets for example) OR living in a homeless emergency shelter).	
2. Has had four (4) episodes of homelessness in the last three (3) years that total 12 months.	

Name and Title of Provider (Last, First, Middle Initial):	
Facility/Organization Name:	
Telephone:	Email:
Signature	Date

☐ I certify that by signing this document I am a provider of homeless services, and I understand that any false statement, omission, or misrepresentation may result in prosecution under state and federal laws. I agree to submit, if requested by Nebraska DHHS MLTC, any additional information in support of this attestation. I also certify that I have obtained the beneficiary's written consent to provide the Nebraska DHHS MLTC this information.