

**Medicaid Work Requirements - Individual Declaration Form**

|               |                                         |           |
|---------------|-----------------------------------------|-----------|
| First Name    | Middle Initial                          | Last Name |
| Address       |                                         |           |
| Date of Birth | Last 4 digits of Social Security Number |           |

Individual eligible for Nebraska Medicaid through Medicaid expansion are required to demonstrate compliance with Medicaid work requirements to qualify for Medicaid coverage.

This form is intended to be used by such individuals to provide information which demonstrates compliance with Medicaid work requirements.

This form only accepts attestation for the activities listed below. There may be other activities not listed that require a different form of verification. For more information regarding Medicaid work requirements, please visit: [dhhs.ne.gov/Pages/WorkRequirements.aspx](https://dhhs.ne.gov/Pages/WorkRequirements.aspx)

Medicaid expansion includes people who get their health insurance through Nebraska Medicaid and fit the following criteria:

- Are aged 19-64,
- Are not pregnant,
- Are not eligible for Medicare,
- Are not eligible on the basis of a disability,
- Are low income (low income means people who earn up to 138 percent of the federal poverty level which, for 2026, is about \$22,025 per year for a single person or \$45,540 for a family of four), and
- Are a U.S. citizen or meet Medicaid immigration rules.

For questions referencing a qualifying month, see the applicable timeframes below:

- For **new applicants**, or individuals being added to a household, the questions on this form should be answered, and will be assessed based on the month before the month in which the individual applied (last month).
- For **existing members**, the questions on this form should be answered, and will be assessed, based on the time between now and your initial determination or last Medicaid renewal.

**Please answer all questions completely and accurately to the best of your knowledge.** If a question does not apply to you, answer "No" or enter "N/A." Questions marked with an asterisk (\*) are required. Submitting an incomplete form may result in delays in processing your benefits or may result in the denial, termination or decrease in your benefits.

|                                                                                                                                                                                          |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Who is this form being filled out for? *</b>                                                                                                                                          |
| • Name: _____                                                                                                                                                                            |
| • Date of Birth: _____                                                                                                                                                                   |
| • Last 4 of SSN: _____                                                                                                                                                                   |
| <b>Did this individual volunteer in their community in a qualifying month? Yes <input type="checkbox"/> No <input type="checkbox"/></b>                                                  |
| • Number of volunteer hours per month: _____                                                                                                                                             |
| • Name of Organization(s): _____                                                                                                                                                         |
| ■ Address(es): _____                                                                                                                                                                     |
| • Organization Contact(s):                                                                                                                                                               |
| ■ Name(s): _____                                                                                                                                                                         |
| ■ Phone(s): _____                                                                                                                                                                        |
| <b>Did this individual participate in a work program in a qualifying month (including job training or employment services)? Yes <input type="checkbox"/> No <input type="checkbox"/></b> |
| • Number of hours per month: _____                                                                                                                                                       |
| • Name of the Work Program(s): _____                                                                                                                                                     |
| ■ Address(es): _____                                                                                                                                                                     |
| • Work Program Contact(s): _____                                                                                                                                                         |
| ■ Name(s): _____                                                                                                                                                                         |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>■ Phone(s): _____</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <p><b>Was this individual enrolled in school or a career and technical education program in a qualifying month?</b><br/> Yes <input type="checkbox"/> No <input type="checkbox"/></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <p>If yes, please complete the following:</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <p>■ Name of school or program: _____</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <p>■ Enrolled full-time? Yes <input type="checkbox"/> No <input type="checkbox"/></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <p>■ Enrolled half-time? Yes <input type="checkbox"/> No <input type="checkbox"/></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <p>■ Enrolled less than half-time? Yes <input type="checkbox"/> No <input type="checkbox"/><br/> ◦ If less than half-time, number of hours enrolled: _____</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <p>■ Enrollment begin date: _____</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <p>■ Anticipated graduation date (if applicable): _____</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <p><b>Is this individual -- or was this individual during a qualifying month -- a parent, guardian, caretaker relative, or family caregiver of a disabled individual?</b> Yes <input type="checkbox"/> No <input type="checkbox"/></p>                                                                                                                                                                                                                                                                                                                                                                                               |
| <p>• Describe the chronic or other health condition, disability, or functional limitation of the individual to whom care is provided: _____<br/> _____</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <p>• (Mark/answer all that apply):<br/> • Does the disabled individual live in your household? Yes <input type="checkbox"/> No <input type="checkbox"/><br/> • Is the disabled individual a relative? Yes <input type="checkbox"/> No <input type="checkbox"/><br/> ■ If no to the above question, describe your relationship to the individual being provided care: _____<br/> ■ If no to the above questions, how many hours of caregiving are provided per month? _____</p>                                                                                                                                                       |
| <p><b>Is this individual -- or was this individual during a qualifying month -- a parent, guardian, caretaker relative, or family caregiver of a child 13 years or younger?</b> Yes <input type="checkbox"/> No <input type="checkbox"/></p>                                                                                                                                                                                                                                                                                                                                                                                         |
| <p>(Mark/answer all that apply):</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <p>• Does the child live in your household? Yes <input type="checkbox"/> No <input type="checkbox"/></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <p>• Is the child a relative? Yes <input type="checkbox"/> No <input type="checkbox"/></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <p>■ If no to the above questions, describe your relationship to the child being provided care: _____</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <p>■ If no to either of the above questions, how many hours of caregiving are provided per month? _____</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <p><b>Has the individual been incarcerated in the last 12 months?</b> Yes <input type="checkbox"/> No <input type="checkbox"/></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <p>• Most Recent Release Date: _____</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <p>■ <input type="checkbox"/> Check here if the individual is still incarcerated</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <p>• Name of Facility: _____</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <p>■ Address: _____</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <p><b>Is this individual - or was this individual during a qualifying month - considered medically frail or do they otherwise have special medical needs?</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <p><b>This includes anyone who is blind or disabled, has a substance use disorder, has a disabling mental disorder, has a physical, intellectual, or developmental disability that significantly impairs their ability to perform one or more activities of daily living (for example bathing, dressing, eating, or toileting), or who has a serious or complex medical condition.</b> Yes <input type="checkbox"/> No <input type="checkbox"/></p>                                                                                                                                                                                  |
| <p>• This individual (check all that apply):<br/> <input type="checkbox"/> Is blind or disabled (as determined by the Social Security Administration or Nebraska State Review Team)<br/> <input type="checkbox"/> Has a substance abuse disorder<br/> <input type="checkbox"/> Has a disabling mental disorder<br/> <input type="checkbox"/> Has a physical, intellectual, or developmental disability that significantly impairs their ability to perform one or more activities of daily living (for example bathing, dressing, eating, or toileting)<br/> <input type="checkbox"/> Has a serious or complex medical condition</p> |

|                                                                                                                                                                                                                                                                                                                                                  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>Describe the health condition(s) the individual has that fit the list above : _____<br/>         _____<br/>         _____</li> </ul>                                                                                                                                                                      |
| <ul style="list-style-type: none"> <li>What doctor(s) or healthcare provider(s) does the individual see for these health conditions?             <ul style="list-style-type: none"> <li>■ Name(s): _____</li> <li>■ Address(es): _____</li> <li>■ Telephone number(s): _____</li> </ul> </li> </ul>                                              |
| <ul style="list-style-type: none"> <li>Were services provided related to the above health condition(s) while the individual was enrolled with Nebraska Medicaid? Yes <input type="checkbox"/> No <input type="checkbox"/></li> </ul>                                                                                                             |
| <b>Is this individual -- or was this individual during a qualifying month -- participating in a drug addiction or alcohol treatment and rehabilitation program? (If so, answer the following based on the most recent participation.)</b> Yes <input type="checkbox"/> No <input type="checkbox"/>                                               |
| <ul style="list-style-type: none"> <li>Name of Facility: _____             <ul style="list-style-type: none"> <li>■ Facility Address: _____</li> <li>■ Contact Name: _____</li> <li>■ Phone: _____</li> </ul> </li> </ul>                                                                                                                        |
| <ul style="list-style-type: none"> <li>Date(s) of Service: _____</li> </ul>                                                                                                                                                                                                                                                                      |
| <ul style="list-style-type: none"> <li>Were these services provided while the individual was enrolled with Nebraska Medicaid? Yes <input type="checkbox"/> No <input type="checkbox"/></li> </ul>                                                                                                                                                |
| <b>Is this individual -- or was this individual during a qualifying month -- a veteran with a VA disability rating of 100% (total)?</b> Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                                                                                                 |
| <ul style="list-style-type: none"> <li>If yes, effective date of disability rating: _____</li> </ul>                                                                                                                                                                                                                                             |
| <b>Did this individual receive inpatient hospital services, nursing facility services, services in an intermediate care facility for individuals with intellectual disabilities (ICF/DD), inpatient psychiatric hospital services, or other similar services in a qualifying month?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> |
| <ul style="list-style-type: none"> <li>Date(s) of Service: _____</li> </ul>                                                                                                                                                                                                                                                                      |
| <ul style="list-style-type: none"> <li>Name of Facility: _____</li> </ul>                                                                                                                                                                                                                                                                        |
| <ul style="list-style-type: none"> <li>Were these services provided while the individual was enrolled with Nebraska Medicaid? Yes <input type="checkbox"/> No <input type="checkbox"/></li> </ul>                                                                                                                                                |
| <b>Did this individual (or their dependent) travel outside of their community for an extended period of time to receive medical care for a serious medical condition during a qualifying month?</b> Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                                     |
| <ul style="list-style-type: none"> <li>Date(s) of Service: _____</li> </ul>                                                                                                                                                                                                                                                                      |
| <ul style="list-style-type: none"> <li>Name of Facility(s): _____             <ul style="list-style-type: none"> <li>■ Address(es): _____</li> </ul> </li> </ul>                                                                                                                                                                                 |
| <ul style="list-style-type: none"> <li>Name of individual(s) receiving medical care: _____</li> </ul>                                                                                                                                                                                                                                            |
| <ul style="list-style-type: none"> <li>Describe the health condition(s) being treated: _____<br/>         _____</li> </ul>                                                                                                                                                                                                                       |
| <ul style="list-style-type: none"> <li>Reason for travel outside the individual's community: _____<br/>         _____</li> </ul>                                                                                                                                                                                                                 |
| <ul style="list-style-type: none"> <li>Were these services provided while the individual was enrolled with Nebraska Medicaid? Yes <input type="checkbox"/> No <input type="checkbox"/></li> </ul>                                                                                                                                                |

I hereby authorize the Nebraska Department of Health and Human Services and its agents to request from third parties any information or documents necessary for the administration of its programs. Such third parties shall include but not be limited to: the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, a consumer reporting agency, and financial institutions. Any third party shall also be authorized to provide any information or documents requested by the Nebraska Department of Health and Human Services concerning myself or, when required by law, any other person. I further authorize the Nebraska Department of Health and Human Services to release such information or documents to cooperating State or Federal Agencies in accordance with any applicable law.

This authorization is given only to the Nebraska Department of Health and Human Services to be used in the administration of its programs and for no other purposes. It shall continue in effect until the earliest of the rendering of a final adverse decision on my application for medical assistance, the cessation of my eligibility for medical assistance, or such time as I state in writing that I rescind this authorization.

I release any third party from any and all liability to me and, when applicable, any other person, for supplying the aforementioned information or documents.

**I'm signing this form under penalty of perjury, which means I've provided true answers to all of the questions to the best of my knowledge. I know that I may be subject to penalties under federal law if I intentionally provide false or untrue information.**

**A REPRODUCTION OF THIS RELEASE IS AS VALID AS THE ORIGINAL**

|                                                          |                |
|----------------------------------------------------------|----------------|
| _____<br>Applicant/Beneficiary Signature                 | _____<br>Date: |
| _____<br>Signature and Relationship of Person Who Helped | _____<br>Date: |

I hereby authorize the Nebraska Department of Health and Human Services and its agents to request from third parties any information or documents necessary for the administration of its programs, including financial information. I also authorize the release of my Social Security Number for this purpose.

|                             |
|-----------------------------|
| <b>Additional comments:</b> |
|                             |
|                             |

If you would like to fill out this form electronically, scan this QR code or go online to [iServe.Nebraska.gov](http://iServe.Nebraska.gov) for more information



**English**

The Nebraska Department of Health and Human Services provides language assistance services and auxiliary aids and services, free of charge. For language assistance services or auxiliary aids, please call (402) 471-3121 or speak to someone at the front desk.

**Spanish**

El Departamento de Salud y Servicios Humanos de Nebraska proporciona servicios de asistencia lingüística y ayudas y servicios auxiliares, de forma gratuita. Para servicios de asistencia lingüística o ayudas auxiliares, por favor llame al (402) 471-3121 o hable con alguien en la recepción.

**Vietnamese**

Sở Y tế và Dịch vụ Nhân sinh Nebraska cung cấp dịch vụ hỗ trợ ngôn ngữ và các thiết bị hỗ trợ bổ trợ, hoàn toàn miễn phí. Để được hỗ trợ ngôn ngữ hoặc sử dụng các thiết bị hỗ trợ bổ trợ, vui lòng gọi số (402) 471-3121 hoặc trao đổi với nhân viên tại quầy lễ tân.

**Arabic**

تقدم دائرة الصحة والخدمات الإنسانية في نبراسكا خدمات المساعدة اللغوية والوسائل المساعدة والخدمات الإضافية مجاناً. للحصول على خدمات المساعدة اللغوية أو الوسائل المساعدة، يُرجى الاتصال على الرقم (402) 471-3121 أو التحدث إلى أحد الموظفين في مكتب الاستقبال.

**French**

Le Département de la Santé et des Services Sociaux du Nebraska propose gratuitement des services d'assistance linguistique et des aides et services auxiliaires. Pour obtenir ces services, veuillez appeler le (402) 471-3121 ou vous adresser à l'accueil.

**Chinese**

內布拉斯加州衛生和公共服務部免費提供語言援助服務和輔助工具和服務。如需語言輔助服務或輔助工具，請致電（402） 471-3121 或與前臺人員聯系。

**German**

Das Gesundheits- und Sozialministerium von Nebraska bietet kostenlose Sprachunterstützung sowie Hilfsmittel und Dienstleistungen an. Für Sprachunterstützung oder Hilfestellungen wenden Sie sich bitte an die Telefonnummer (402) 471-3121 oder sprechen Sie mit einem Mitarbeiter an der Rezeption.

**Somali**

Waaxda Caafimaadka iyo Adeegyada Aadanaha ee Nebraska waxay bixiyaan adeegyada kaalmada luqadda iyo qalabka caawiyo dadka wax maqalka ku adeegyahay oo bilaash ah. Adeegyada kaalmada luqadda ama qalabka caawiyo dadka wax maqalka ku adeegyahay, fadlan wac (402) 471-3121 ama la hadal qofka jooga soo dhaweynta.

**Swahili**

Idara ya Afya na Huduma za Kibinadamu ya Nebraska hutoa huduma za usaidizi wa lugha na usaidizi wa ziada na huduma, bila malipo. Kwa huduma za usaidizi wa lugha au usaidizi wa ziada, tafadhali piga simu (402) 471-3121 au zungumza na mtu aliye kwenye dawati la mapokezi.

**Nepali**

नेब्रास्का स्वास्थ्य तथा मानव सेवा विभागले भाषा सहायता सेवाहरू र सहायक सहायता र सेवाहरू निःशुल्क प्रदान गर्दछ। भाषा सहायता सेवाहरू वा सहायक सहायताहरूको लागि, कृपया (402) 471-3121 मा कल गर्नुहोस् वा फ्रन्ट डेस्कमा कसैसँग कुरा गर्नुहोस्।

**Tagalog**

Nagbibigay ang Nebraska Department of Health and Human Services ng mga serbisyonang pantulong sa wika at mga karagdagang tulong at serbisyo, nang walang bayad. Para sa mga serbisyonang pantulong sa wika o mga karagdagang tulong, mangyaring tumawag sa (402) 471-3121 o makipag-usap kaninuman sa front desk.

**Russian**

Департамент здравоохранения и социальных служб штата Небраска предоставляет бесплатные услуги языковой поддержки, а также вспомогательные средства и услуги. Для получения услуг языковой поддержки или вспомогательных средств позвоните по телефону (402) 471-3121 или обратитесь к кому-нибудь на стойке регистрации.

**Ukrainian**

Департамент охорони здоров'я та соціальних служб штату Небраска надає безкоштовні послуги мовної підтримки, а також допоміжні засоби та послуги. Для отримання послуг мовної підтримки або допоміжних засобів зателефонуйте (402) 471-3121 або зверніться до когось на стійці реєстрації.

**Telugu**

నెబ్రాస్కా డిపార్ట్మెంట్ ఆఫ్ హెల్త్ అండ్ హ్యూమన్ సర్వీసెస్ భాషా సహాయ సేవలు మరియు సహాయక సహాయాలు మరియు సేవలను ఉచితంగా అందిస్తుంది. భాషా సహాయ సేవలు లేదా సహాయక సహాయాల కోసం, దయచేసి (402) 471-3121 కు కాల్ చేయండి లేదా ముందు డెస్క్ వద్ద ఉన్న ఎవరితోనైనా మాట్లాడండి.

**Hindi**

द नेब्रास्का डिपार्टमेंट ऑफ हेल्थ एंड ह्यूमन सर्विसेज़ मुफ्त भाषा सहायता सेवाएं तथा सहायक साधन एवं सेवाएं प्रदान करता है। भाषा सहायता सेवाओं या सहायक साधनों के लिए, कृपया (402) 471-3121 पर कॉल करें या फ्रंट डेस्क पर किसी से बात करें।