STATE OF NEBRASKA

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FINANCIAL QUESTIONNAIRE (USED FOR DETERMINING ABILITY TO PAY)

Name	Age	DOB	Marital Status	Social Security Number

Address, City, State and Zip Code	County	Length of Time at Present Address

Previous Address	County	No. of Dependents	Mo Rent or Payment

Have you ever received treatment in a State operated facility?
Where?

Employer	Address	Gross Monthly Income

OTHER MONTHLY INCOME

Interest	Dividends	Royalties			AMOUNT
$	$	$			$0.00
Paying Agency and Address					
Rental Income $	Social Security $	Veterans $	Railroad $		$0.00
Address of Rental Property					
Miscellaneous Income (Specify)					$

LIABILITIES (Long term bills owed)

Company	Address	Mo Payment	Balance Due
		Total Liabilities	$0.00

HEALTH INSURANCE INFORMATION

Do you have health insurance? Yes/No If yes please see Statement of Hospitalization Insurance Coverage Form

ASSETS (Things of value that you own)

		AMOUNT
Checking Accounts		$
Name of Bank	Address	
Savings Accounts		$
Name of Bank	Address	
Farm Machinery		$
Livestock		$
Real Estate		$

Home	Address	
		$
		$
		$
		$

Miscellaneous Assets (Specify)	$

Stocks, Bonds, C.D.'s		$
Automobile Make	Year	
		$
		$
		$

Accounts Receivable	
Total Assets	$0.00

Did you file a State of NE Income Tax Return last year? **Yes or No**

RELATIVE - Please note whether husband, wife, parent or guardian

Name	Address	Age

IMPORTANT: This form must be completed and returned **within 30 days**; otherwise, full charges will be assessed on the individual. **STATE LAW** provides that those electing to disclose financial information along with copies of their most recent income tax return will only be liable to their extent of ability to pay. However, the responsibility of submitting the necessary financial information is the individual's or relative's; and if such financial information is not disclosed, full cost for care and treatment will be assessed.

I certify that the above statements are true and understand that any willfull misstatement or misrepresentation will void any agreement and result in the full charge being due and payable.

Date: ____________________ Signed: ____

(Individual, Spouse or Legal Representative)

Phone or Cell Number:

Statement of Hospitalization Insurance Coverage

1. Patient: ______________________________ Date Admitted: ____________________
2. Home Address: ____
3. Do you have health insurance coverage? ______________________________________
4. Name of Insured: ________________________ DOB: _____________ Relation to Patient: __________
5. Address: ____ Phone: ____________
6. Employer of Insured: ____
7. Address: ____ Phone: ____________
8. Name of Insurance Company: ___________________________ Phone: ____________
9. Address: ____
10. Policy Number: ____

Insurance Authorization and Assignment

Authorization is hereby granted to release such information as may be necessary for the completion of insurance forms for hospitalization and disability claims.

I hereby authorize payment directly to the Lincoln Regional Center of any and all hospital and medical care insurance benefits to which I may be entitled, as a result of service from said hospital. The amount to be paid to said hospital under this assignment shall not exceed the usual charges for such services incurred by me. (A photocopy of this authorization shall be as valid as the original.)

______________________________ X______________________________
Print Name Signature

______________________________ ______________________________
Date Relationship to Patient

Patient's HIPAA Privacy Rights. The patient acknowledges that any protected health information contained in this form is entitled to HIPAA Act of 1996 protections. The patient, as a result, receives Privacy rights such as: limited use and disclosure by State of Nebraska and its business associates; minimum-necessary information access in medical decision making; opportunity for patient to request information withholding and authorization for further disclosure; right to review his/her own medical information (treatment, diagnosis and claims payment) and to make corrections if necessary; and a process to make privacy violation complaints. For more details regarding HIPPAA privacy rights, the patient may request a detailed copy of Nebraska's "Notice of Privacy". The signature here demonstrates the patient's awareness to such rights.

______________________________ X______________________________
Print Name Signature

______________________________ ______________________________
Date Relationship to Patient

Lincoln Regional Center
PO Box 94949
Lincoln, NE 68509-4949
Insurance Department: 402-479-5420

NEBRASKA TAX RETURN COPY REQUEST	FORM 23

TO: **The Nebraska Department of Revenue**

I hereby certify that I authorize the release of my tax return(s), the information contained therein, and the mailing thereof, for the tax years indicated below, including future tax years, as requested by Nebraska Health & Human Services to determine my ability to pay for services I receive (or will receive) from state institutions or community-based providers, in accordance with Nebraska statutes and administrative codes, chapter 1.

☐	☐	☐	☐	☐	☐	☐

CLIENT NAME		**SSN**
CLIENT SIGNATURE		**DATE**
SPOUSE NAME **(Joint Return Only)**		**SSN**
SPOUSE SIGNATURE (or AUTHORIZED REPRESENTATIVE SIGNATURE)		**DATE**

Authorized representative check one of the following: ☐ Power of Attorney ☐ * Court Appointed Guardian ☐ * Court Appointed Conservator ☐ Other (Describe) ____________________

Authorized Mailing Address for Return:

Lincoln Regional Center
PO Box 94949
Lincoln, NE 68509
Fax# (402) 742-1153

* ATTACH PROOF OF GUARDIANSHIP OR CONSERVATORSHIP

Name: ______________________ Client No: _____________ Adm. Date: ____________

United States Citizenship Attestation Form

For the purpose of complying with Neb. Rev. Stat. §§ 4-108 through 4-114, I attest as follows:

______ I am a citizen of the United States.

— OR —

______ I am a qualified alien under the federal Immigration and Nationality Act, my Immigration status and alien number are as follows: ______________________, and I agree to provide a copy of my USCIS documentation upon request.

I hereby attest that my response and the information provided on this form and any related application for public benefits are true, complete, and accurate and I understand that this information may be used to verify my lawful presence in the United States.

PRINT NAME ____
(first, middle, last)

SIGNATURE ______________________________ **DATE** ______________________

NEBRASKA

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DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

I ________________________________ hereby authorize ____________________
(signature and date) (Name of Bank)
____ to release the following

information to the Lincoln Regional Center, Lincoln, NE and also by a faxed copy no later than
________________________:

Amount in any checking account or joint account ______________________.
Amount in any savings account or joint account ______________________.
Amount in any time certificates or joint account ______________________.
Amount in any trust account or joint account ________________________.
Amount in any other assets in the bank or joint account ________________.
Amount on house loan ____.
Amount on car loan ____.
Amount on loan ____.
Account Number(s) ____.

Please return the completed form to the following address:

Lincoln Regional Center
Financial Responsibility
PO Box 94949
Lincoln, NE 68509-4949

Thank you.

(FOR BANK USE ONLY)
Verified By ______________________
Title ______________________
Date ______________________

18618

Verification of Deposit

Medical or Public Assistance Agencies

WELLS FARGO

For faster processing, please complete the form on your computer before printing.

This form is for medical or public assistance agencies requesting consumer deposit information. Please complete the form including the customer authorization signature and fax to the number below. Your completed request will be faxed to the return fax number provided on this form.

TYPE or complete in BLACK INK. Use only CAPITAL LETTERS

Fax Requests To......1-844-879-0412
Online Instructions......www.wellsfargo.com/biz/vod
Balance Confirmation Services......1-540-563-7323

SECTION 1: REQUESTER INFORMATION

LINCOLN REGIONAL CENTER
Company Name

FINANCIAL RESPONSIBILITY
Attention

PO BOX 94949
Street Address

LINCOLN
City

NE
State

68509
Zip

Requester Email (optional)

402-479-5421
Requester Phone Number

402-742-1153
Return Fax Number

SECTION 2: CUSTOMER INFORMATION

Customer One Full Name (First Middle Last)

Customer Two Full Name (First Middle Last)

Account Number(s) (Required)

Customer One Social Security Number

__ / __ / 20__
Month Day Year

CUSTOMER AUTHORIZATION

I/We authorize and direct Wells Fargo Bank to release the following information to the above mentioned requestor on my deposit accounts listed above or if only a Social Security Number is provided, all open depository accounts: Account Number, Account Type, Open or Closed, Account Holder(s), Current/Closing Balance, Open/Close Date, Current Interest Rate, Previous Six Average Statement Balances and Previous Six Months Interest Paid. In addition, CDs and IRAs will include: Term, Maturity Date, Interest Payment, Interest Method and Penalty.

Signature of Account Holder **Date** **Signature of Account Holder** **Date**

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DEPT. OF HEALTH AND HUMAN SERVICES

Nebraska Department of Health and Human Services
Authorization for Disclosure of Protected Health Information

Failure to sign this form will not affect treatment or payment, however it may affect enrollment, or eligibility for certain benefits provided by the Nebraska Department of Health and Human Services. I understand the advantages and disadvantages and freely and voluntarily give permission to release specific information about me. I also understand that I am not required to disclose my social security number, though disclosure may make it easier or quicker for information to be provided.

Client Name (Last, First, Middle Initial)		Date of Birth
Social Security Number	Case/Chart # (if known)	Period Covered Admission of:

Information will be disclosed to:	Reason for Disclosure:
Name:	☐ Eligibility Determination ☐ My Request ☐ Insurance Claim ☐ Legal Purposes ☐ Consultation and/or Treatment ☐ Planning ☐ Other (be specific): ______________
Address 1:	
Address 2:	
City, State, Zip:	
The information to be released pursuant to this authorization is limited to records or information from or in the possession or control of DHHS (or other party, as applicable).	

Specific Information to be Disclosed:

☐ All information that can be disclosed to me relating to the Adult Abuse and Neglect Central Registry and the Child Child Abuse and Neglect Central Registry.

☐ All other non-medical information, records, or documents relating to me which the Department of Health and Human Services could release directly to me.

☐ Entire Medical Record

OR:

- ☐ Aftercare Referral Form
- ☐ Discharge Summary
- ☐ Diagnosis
- ☐ History & Physical Examination
- ☐ Laboratory
- ☐ Medications
- ☐ Progress Notes
- ☐ Psychiatric History & Treatment
- ☐ Psychological Evaluation & Treatment
- ☐ Social History
- ☐ X-rays & Other Diagnostic Imaging Results

- ☐ Alcohol and/or Drug Abuse Treatment
- ☐ Genetic Testing Information
- ☐ HIV/AIDS Information
- ☐ Sickle Cell Anemia Information

☐ Other (be specific): ______________

This Authorization (unless revoked earlier in writing) shall terminate on______________ (must have date or event filled in). By signing this authorization, I acknowledge that the information to be released may include material that is protected by federal or state law, including benefit or enrollment information; or protected health information that may include Drug/ Alcohol, HIV, or sickle cell anemia related information. My signature authorizes release of indicated information. I also understand this authorization may be revoked at any time by submitting a written request in accordance with the then current DHHS Notice of Privacy Practices (if to DHHS), or by submitting a written request to the health care provider, health care entity, or otherwise (if to anyone else),a n d it will be honored with the exception of information that has already been released. I also understand if the recipient of the information is not a health plan or health care provider, the information may no longer be protected by privacy laws.

Client's Signature		Date
Authorized Representative's Signature	Authorized Representative's Printed Name	Date
Authorized Representative (Select One): ☐ Parent ☐ Guardian ☐ Power of Attorney ☐ Personal Representative		
Witness's Signature	Witness's Printed Name	Date

NOTICE TO RECIPIENT: This information has been disclosed to you from records whose confidentiality is protected by state and federal laws (including Federal Regulations, 38 CFR 1.460-1.499, 42 CFR Part 2 and Part 431, Subpart F) which prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR Part 2. The federal rules restrict the use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at 42 CFR 2.12(c)(5) and 2.65 . A general authorization for the release of medical or other information is NOT sufficient for this purpose.

PLEASE FILL OUT THIS FORM COMPLETELY

NEBRASKA
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DEPT. OF HEALTH AND HUMAN SERVICES

Nebraska Department of Health and Human Services

AFFIDAVIT FOR OUTPATIENTS MEDICATION REQUEST FORM (MH004) MH004

Financial Responsibility
P.O. Box 94949
Lincoln, NE 68509

STATE OF NEBRASKA: COUNTY OF ____________________________) SS.

The undersigned, being first duly sworn deposes and says that:

The patient's name is ____, and patient is _______years of age, and resides at ____; and

The patient has been discharged from Mental Health Board ordered treatment from the facility identified as ____; and

(a) The patient qualifies as a person who is unable to pay under the same standards of ability to pay set forth in Neb.Rev. Stat., §§ 83-363 to 83-380, and will submit information to the Financial Responsibility Division of the Department of Health and Human Services upon its request, to substantiate that fact;

(b) That prescription medication has been prescribed as necessary for the patient's mental health treatment; and

(c) That the patient's treating physician is

Dr.____

whose address is____

____
(Signature of Patient or Guardian)

____
Typed name of Affiant

Subscribed in my presence and sworn to before me this _____ day of ______________________________, _______.

Notary Seal

____
Notary Public

OFFICE USE ONLY

DHHS/Financial Responsibility ______________________________ Date ___/___ / ___
Signature

Center Pharmacist______________________________ Date ___/___ / ___
Signature

White – Financial Responsibility Division   Yellow – Pharmacist   Pink – Patient's Record