

## Applying for Developmental Disabilities Services

### How to apply for developmental disabilities services online

To apply for developmental disabilities services with DHHS follow these steps:

1) Start by clicking on ACCESSNebraska wherever you see the icon.



2) You can enter the site in English or Spanish. Click on ENTER in English to do so.



3) To apply for developmental disabilities services, click Developmental Disabilities Application.

A screenshot of the ACCESS Nebraska website home page. The top banner features a collage of diverse people and the ACCESS Nebraska logo. A sidebar on the right lists "Other Useful Links" including DHHS Programs, Community Service, Printable Forms, Community Partner, How to?/Tutorials, SNAP EBT/ReliaCard, and Contact Us. Below the banner is an "IMPORTANT NOTICE: EBT cards cannot be used be" (partially cut off). The main content area is a grid of service application boxes: "My Account", "Economic Assistance Application", "Developmental Disabilities Application" (highlighted with an orange arrow), and "Healthcare/Medicaid Application". Below this grid are three more boxes: "Do I Qualify?", "Submit Documents", and "Report Changes".

My Account	Economic Assistance Application	Developmental Disabilities Application	Healthcare/Medicaid Application
<ul style="list-style-type: none"><li>View Current Benefits</li><li>View Correspondence</li><li>Select Correspondence Delivery Preferences</li><li>Complete Medicaid Renewal</li></ul>	<ul style="list-style-type: none"><li>Complete an application for most DHHS benefits</li><li>Re-apply for continuous benefits (Recertification/Review) for DHHS programs except for Medicaid</li></ul>	<ul style="list-style-type: none"><li>Complete an application for Developmental Disabilities Services</li></ul>	<ul style="list-style-type: none"><li>Apply for Medicaid,</li><li>Federal Insurance Affordability Programs, or</li><li>Qualified Healthcare plans</li></ul>

Do I Qualify?	Submit Documents	Report Changes
<ul style="list-style-type: none"><li>Online assessment to see which programs may fit your needs</li><li>Determine if you qualify for any programs</li></ul>	<ul style="list-style-type: none"><li>Upload/submit documents to DHHS</li><li>Must be currently applying or receiving benefits to use this feature.</li></ul>	<ul style="list-style-type: none"><li>Report changes in your household</li><li>Must be currently applying or receiving benefits to use this feature.</li></ul>

4) Instructions for the application will open in a new window. Once you have read the instructions, including assistance with the form and supporting documentation/records, click CONTINUE to apply online.

**Welcome to ACCESSNebraska Developmental Disabilities Application**

**The application for DD Services is now available on the ACCESSNebraska website.**

- This online application has replaced the previous 'referral' process. Therefore, the old 'referral form' is no longer necessary.
- An application for DD Services must be completed and signed by the applicant, the parent if the applicant is a minor child, or the applicant's court appointed guardian.
- The process of determining eligibility for DD Services does not begin until a signed application has been received by the Department of Health and Human Services.

**Third Party Assistance:**

If you are a third party providing assistance to an individual who's applying for DD Services, applications can also be submitted by one of the following ways:

- Printing and completing a paper copy of the application that's available on the [Developmental Disabilities public website](#). The applicant or legal guardian must sign the application.
- Contacting the Department of Health and Human Services using the toll free number (877)667-6266.
- Or go to any local DHHS office for assistance.

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**Supporting Documentation/Records:**

After the Department of Health and Human Services receives your submitted application, DHHS may request documentation that's needed to determine eligibility for DD Services.

The types of documents which may be requested include, but are not limited to, the following:

- Assessments for intellectual or adaptive behavioral functioning completed by a licensed psychologist
- Medical diagnoses prior to age 22 which have affected the applicant's ability to carry out activities of daily living
- Current or previous psychiatric diagnoses prior to age 22 which have affected the applicant's ability to carry out activities of daily living
- Educational reports such as Multi-Disciplinary Team (MDT) reports and Individual Education Plans (IEP)

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After the application for DD Services has been submitted, the applicant or legal guardian may send records or documentation to support the applicant's eligibility to one of the addresses listed below:

**Mail:** DD Eligibility  
PO Box 98947  
Lincoln, NE 68509


**Email:** [DHHS.DDEligibility@nebraska.gov](mailto:DHHS.DDEligibility@nebraska.gov)

**Fax:** (402)742-8384

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Select Continue to start the application process. After the application has been submitted, a Confirmation page with your confirmation number will be displayed. This confirmation number is proof that your application has been submitted.

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**CONTINUE**

5) Know if you already have an ACCESSNebraska account.

**Welcome to ACCESSNebraska Developmental Disabilities Application**

This site allows you to apply for Developmental Disabilities Services. The process begins by creating an account or logging in using your ACCESSNebraska User ID and Password. By creating an account, your draft application will be available for you to complete for 30 days.


**Establish a User ID and Password**

- First, create your User ID (such as your personal email address) and set the password.

**Choose your Security Questions**

- Select and answer three security questions. If you forget your password, you can reset your password by answering the security questions correctly.

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**CONTINUE**

## 6) Login using existing account

### Login

<b>Returning User</b> Please log In Enter your User ID and Password to Login User ID <input type="text"/> Password <input type="password"/> <a href="#">Forgot User ID</a> <a href="#">Forgot/Change Password</a> <input type="button" value="Login"/> <input type="button" value="Clear"/>	<b>New User</b> <a href="#">Create an Account</a>
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THIS IS A GOVERNMENT COMPUTER SYSTEM. UNAUTHORIZED ACCESS IS PROHIBITED. ANYONE USING THIS SYSTEM IS SUBJECT TO MONITORING. UNAUTHORIZED ACCESS OR ATTEMPTS TO USE, ALTER, DESTROY OR DAMAGE DATA, PROGRAMS OR EQUIPMENT COULD RESULT IN CRIMINAL PROSECUTION.....

**OR** Create an ACCESSNebraska account by following instructions.

### Login

<b>Returning User</b> Please log In Enter your User ID and Password to Login User ID <input type="text"/> Password <input type="password"/> <a href="#">Forgot User ID</a> <a href="#">Forgot/Change Password</a> <input type="button" value="Login"/> <input type="button" value="Clear"/>	<b>New User</b> <a href="#">Create an Account</a>
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THIS IS A GOVERNMENT COMPUTER SYSTEM. UNAUTHORIZED ACCESS IS PROHIBITED. ANYONE USING THIS SYSTEM IS SUBJECT TO MONITORING. UNAUTHORIZED ACCESS OR ATTEMPTS TO USE, ALTER, DESTROY OR DAMAGE DATA, PROGRAMS OR EQUIPMENT COULD RESULT IN CRIMINAL PROSECUTION.....

When creating a password, it must:

- Be between 8-10 characters long;
- Include at least 1 number, but the first character cannot be a number;
- Cannot include symbols;
- Cannot repeat any character sequence more than 2 times;
- Have at least 1 lowercase and 1 uppercase letter; and
- May not include: password, husker, or admin.

### New Account Registration

Language

* First Name	<input type="text"/>
* Last Name	<input type="text"/>
* User ID	<input type="text"/>
* Password	<input type="password"/>
* Retype Password	<input type="password"/> <a href="#">Password Rules</a>
* Security Question 1	<<select>>
* Answer 1	<input type="text"/>
* Security Question 2	<<select>>
* Answer 2	<input type="text"/>
* Security Question 3	<<select>>
* Answer 3	<input type="text"/>

\*Items marked with asterisk are required fields.


7) Once you are logged in, or register, you will be asked if you want to change your password. Unless you want to create a new password, click CONTINUE.

### Security

**Your Log In was successful. You may click a link below or press continue.**

- I want to change my password: [Change Password](#)

**\* Warning: After changing your password, you will be logged off and then will need to log back on before continuing.**



8) Read the “Important Information” screen and click CONTINUE.

### Important Information

This application is to determine eligibility for Developmental Disabilities Services (DD Services), as defined in [Neb. Rev. Stat. § 83-1205](#). This is not an application for:

- Medicaid
- Social Security
- Economic Assistance or
- Behavioral Health services

If you would like to apply for Medicaid or Economic Assistance please return to the ACCESSNebraska Menu and select the appropriate button.

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**Am I eligible for DD Services?**

This decision is based on meeting the criteria in [Neb. Rev. Stat. § 83-1205](#):

- **Intellectual Disability**
  - Diagnosis by a Clinical Licensed Psychologist is required.
  - Substantial limitations in three (3) or more major life activity areas as determined by adaptive assessments such as an ABAS, Vineland or SIB-R.

OR

- **Developmental Disability**
  - May include a medical diagnosis such as cerebral palsy, spina bifida, or certain genetic disorders such as Fragile X or Down syndrome
  - Substantial limitations in three (3) or more major life activity areas as determined by adaptive assessments such as an ABAS, Vineland or SIB-R.

**The Intellectual Disability or Developmental Disability must be present in the developmental years prior to the age of twenty-two (22).**

However, an individual from birth to the age of nine (9) years who has a substantial developmental delay or specific congenital or acquired condition may be considered to have a developmental disability without meeting three (3) or more major life activities as described in [Neb. Rev. Stat. § 83-1205](#). Please note that if an individual is determined eligible before the age of nine (9), eligibility will be re-determined at age nine (9) and again at age eighteen (18).

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Only limited funding is available for individuals found eligible for DD Services. Funding is allocated by the Nebraska State Legislature. If found eligible the applicant will:

- Be placed on a Registry of Needs list to wait for available funding; and
- Be given the option to be assigned a Service Coordinator who can answer questions and assist in the location of other possible resources.


Please keep in mind:

- DD Services are voluntary;
- The Division of Developmental Disabilities is not a crisis response agency;
- To receive DD Services the applicant will need to apply for and accept any federal funding for which the applicant may be eligible such as Medicaid;
- The applicant must be a Nebraska resident to remain on the Registry of Needs.
- The applicant must reside in Nebraska to receive DD Services.
- If the applicant is not eligible for Medicaid, the applicant may be required to pay toward the cost of services.

DD Services provides habilitation and vocational training for the eligible individual. DD Services does not provide economic assistance. DD Services funding pays a provider for habilitative services delivered to the eligible individual. DD Services may include:

- Vocational training
- Community inclusion
- Residential services

The goal of habilitation services provided through DD Services funding is to assist individuals in meeting their goals and maximizing independence to become as independent as possible. For some individuals this may mean that DD Services are temporary and for others life-long.



9) Fill out all information about the applicant. If you are helping someone who you are legally responsible for (such as a child or ward), be sure to fill out their information and not yours. When all information is entered, click CONTINUE.

## Applicant Information

Does the applicant have an intellectual or developmental disability?

Yes  No

This question MUST be marked Yes.

Did this intellectual or developmental disability occur before the age of 22?

Yes  No

Is the applicant currently receiving or has the applicant ever received Aged & Disabled waiver services, Traumatic Brain Injury (TBI) waiver services, or other Medicaid & Long-Term Care Services?

Yes  No  Unsure

Does the applicant want to be connected with other services?

Yes  No

First Name

Middle Name

Last Name

Extension

Previous Names

Sex

Male  Female

Date of Birth



Social Security Number

### Physical Address

Address Line 1

Address Line 2

Address Line 3

City

State

Zip Code

### Mailing Address

Address Line 1

Address Line 2

Address Line 3

City

State

Zip Code

Primary Phone Number

Type of Phone

Secondary Phone Number

Type of Phone

Email Address

Has the applicant ever been a child in the legal custody (state ward) of the Nebraska Department of Health and Human Services?  
 Yes  No

Is the applicant a United States citizen?  
 Yes  No

Where was the applicant born?  
 City  State

Is the applicant a qualified alien under the Federal Immigration and Nationality Act?  
 Yes  No

Is the applicant a legal resident of Nebraska?  
 Yes  No

One of these must be marked Yes. Applicant must be US citizen OR a qualified alien under the Federal Immigration and Nationality Act.

This question **MUST** be marked Yes. Applicant must be Nebraska resident.

10) Review applicant information. If the applicant has an authorized representative helping with the application, select "Authorized Representative" and click Add.

### Applicant

**Applicant:** JOHN DOE [Change](#)  
**Date of Birth:** 01-10-1980

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Does the applicant have a person with one of the following roles that will act on the applicant's behalf when working with the Department of Health and Human Services regarding the application? (If so, which one?)

Authorized Representative

Guardianship/Attorney in Fact

Parent of Minor

None of the above

The applicant is 19 years of age or older and authorizes the following representative to provide assistance and consent for release of information. (See Help (under Options) for more information.)

**Authorized Representative** [Add](#)

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**Comments**

[View Detailed Summary](#)

### Authorized Representative Information

**First Name**  **Middle Name**

**Last Name**  **Extension**

**Relationship to Applicant**

**Address**

**Address Line 1**

**Address Line 2**

**Address Line 3**

**City**  **State**

**Zip Code**

**Phone Number**

Enter all information about Authorized Representative. More than one can be entered by clicking Add Another. When done, click CONTINUE.

**AND/OR** on the same screen, if the applicant has a guardian or attorney in fact, select Guardian/Attorney in Fact and click Add.

**Applicant**

Applicant: JOHN DOE [Change](#)  
Date of Birth: 01-10-1980

Does the applicant have a person with one of the following roles that will act on the applicant's behalf when working with the Department of Health and Human Services regarding the application? (If so, which one?)

- Authorized Representative
- Guardianship/Attorney in Fact
- Parent of Minor
- None of the above

The applicant is 19 years of age or older and has a court-appointed guardian or Attorney in Fact (also known as a Power of Attorney or POA).

Guardianship/Attorney in Fact [Add](#)

Comments

[View Detailed Summary](#)

**Guardianship/Attorney in Fact Information**

First Name  Middle Name   
Last Name  Extension   
Address  
Address Line 1   
Address Line 2   
Address Line 3   
City  State   
Zip Code   
Phone Number

Enter all information about guardian or attorney in fact. More than one can be entered by clicking Add Another. When done, click CONTINUE.

**AND/OR** on the same screen, if the applicant is a minor and a parent is their natural guardian, select Parent of Minor and click Add.

**Applicant**

Applicant: JOHN DOE [Change](#)  
Date of Birth: 01-10-1980

Does the applicant have a person with one of the following roles that will act on the applicant's behalf when working with the Department of Health and Human Services regarding the application? (If so, which one?)

- Authorized Representative
- Guardianship/Attorney in Fact
- Parent of Minor
- None of the above

The applicant is a minor child under 19 year of age.

Parent of Minor [Add](#)

Comments

[View Detailed Summary](#)

**Parent of Minor Information**

First Name  Middle Name   
Last Name  Extension   
Address  
Address Line 1   
Address Line 2   
Address Line 3   
City  State   
Zip Code   
Phone Number

Enter all information about the parent of minor. More than one can be entered by clicking Add Another. When done, click CONTINUE.

**OR** on the same screen, if the applicant has none of the above, select None of the above and click CONTINUE.

**Applicant**

**Applicant:** JOHN DOE [Change](#)  
**Date of Birth:** 01-10-1980

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Does the applicant have a person with one of the following roles that will act on the applicant's behalf when working with the Department of Health and Human Services regarding the application? (If so, which one?)

- Authorized Representative
- Guardianship/Attorney in Fact
- Parent of Minor
- None of the above

**Comments**

[View Detailed Summary](#)

**× EXIT****CONTINUE →**





11) Provide contact information for schools and doctors that will support a diagnosis of a developmental disability and/or show your skills. **IT IS IMPORTANT TO COMPLETE THIS SECTION SO DHHS-DD MAY GATHER ALL NECESSARY RECORDS AND MAKE AN ACCURATE DETERMINATION IN A TIMELY MANNER.** When finished click CONTINUE.

In this section, you can supply contact information for doctors and schools that can assist DHHS with determining eligibility for DD Services. Types of records may include but are not limited to:

- Assessments for intellectual or adaptive behavioral functioning completed by a licensed psychologist
- Medical diagnoses prior to age 22 which have affected the applicant's ability to carry out activities of daily living
- Current or previous psychiatric diagnoses prior to age 22 which have affected the applicant's ability to carry out activities of daily living
- Educational reports such as Multi-Disciplinary Team (MDT) reports and Individual Education Plans (IEP)

The Department of Health and Human Services will not contact any doctors or schools for applicant records unless the applicant (or applicant's legal guardian) has provided the necessary authorization. You can provide this authorization to DHHS by the applicant or the legal guardian completing the Authorization Disclosure Section in this signed and submitted electronic application. Providing the authorization with this application will enable the Department of Health and Human Services to more quickly determine your eligibility.

### Contact Information

Do you want to provide contact information for Educational records?  
 Yes  No  Not Available

**Educational Records** [Add Contact](#)

Do you want to provide contact information for Physician records?  
 Yes  No  Not Available

Do you want to provide contact information for Psychologist records?  
 Yes  No  Not Available

Do you want to provide contact information for Psychiatrist records?  
 Yes  No  Not Available

Do you want to provide contact information for Therapist/Counselor records?  
 Yes  No  Not Available

Comments

[View Detailed Summary](#)

When you select Yes, you will be given the option Add Contact. Click on this option. You may select Yes and enter records for all fields.

**Only click CONTINUE on this screen once all schools and doctors are entered.**

### Contact Information

Applicant Name: JOHN DOE

**Educational Contact Information**

School

Specific Disability

**Address**

Address Line 1

Address Line 2

Address Line 3

City  State  Zip Code

**Phone Number**

Enter all contact information for the professional selected. More than one can be entered by clicking Add Another. When done, click CONTINUE.

12) The authorized disclosure section **must be completed** to give DHHS-DD permission to contact the schools and doctors provided in the previous section. When finished click CONTINUE.

In this section, you can authorize the Department of Health and Human Services to contact and request record information from doctors and schools for whom you've provided contact information in the previous section.

- You will select which types of information DHHS can request.
- You will specify the date this authorization ends or is terminated.
- This information will be used to populate the Authorization for Release of Personal Health Information form.

Providing this authorization with this application will enable the Department of Health and Human Services to more quickly determine your eligibility. The authorization allows information to be disclosed to:

Division of Developmental Disabilities  
Nebraska Department of Health and Human Services  
301 Centennial Mall South  
PO Box 98947, Lincoln, NE 68509-8947

**Or fax:** (402)742-8384  
**Or e-mail:** DHHS.DDEligibility@nebraska.gov

The information to be released pursuant to this authorization is limited to records, applicable parties.

Failure to provide this information will not affect treatment, or payment, however certain benefits, provided per Nebraska Department of Health and Human Service

### Disclosure Authorization

**Authorization for Disclosure of Protected Health Information for JOHN DOE.**

**Reasons for Disclosure**  
This release of information is for the purpose of obtaining source documents/records **ONLY** related to determining DD eligibility. Therefore, we have preselected the reasons for disclosure as indicated below and are not asking that you select any other type of disclosure as it does not pertain to DD eligibility.

Eligibility Determination    My Request    Insurance Claim  
 Legal Purposes    Consultation and/or Treatment Planning    Other (be specific)

Select specific types of information that can be disclosed to the Department of Health and Human Services.

<input type="checkbox"/> All information that can be disclosed to the Adult Abuse and Neglect Central Registry and the Child Abuse and Neglect Central Registry.	<input type="checkbox"/> Aftercare Referral Form
<input type="checkbox"/> Discharge Summary	<input checked="" type="checkbox"/> Diagnosis
<input checked="" type="checkbox"/> History & Physical Examination	<input type="checkbox"/> Laboratory
<input checked="" type="checkbox"/> Medications	<input type="checkbox"/> Progress Notes
<input checked="" type="checkbox"/> Psychiatric History & Treatment	<input type="checkbox"/> All other non-medical information, records, or documents which could be released.
<input checked="" type="checkbox"/> Psychological Evaluation & Treatment	<input checked="" type="checkbox"/> Social History
<input type="checkbox"/> X-rays & Other Diagnostic Imaging Results	<input type="checkbox"/> Alcohol and/or Drug Abuse Treatment
<input checked="" type="checkbox"/> Genetic Testing Information	<input type="checkbox"/> HIV/AIDS Information
<input type="checkbox"/> Sickle Cell Anemia	<input checked="" type="checkbox"/> Vocational Rehabilitation
<input checked="" type="checkbox"/> Education Records	<input type="checkbox"/> Other (be specific)

This Authorization (unless revoked earlier in writing) shall terminate on

[View Detailed Summary](#)

The Reason for Disclosure is automatically completed as Eligibility Determination and My Request. You do not need to do anything in this area.

You must select the types of information you would like your school(s) and/or doctor(s) to provide to DHHS-DD. It is recommended you check those that appear checked in the example.



13) Review application by clicking on Application Summary, Rights and Responsibilities, and Authorization for the Disclosure of Protected Health Information. As you review click the checkbox. Then click CONTINUE.

**Application Submission Section**

Applicant  
Contacts  
Disclosure Authorization  
**Application Submission**

**Review Application**

You must review the application, the Rights and Responsibilities and the Authorization for Disclosure of Protected Health Information to continue.

[Application Summary](#)  
 Yes, I have reviewed the application summary.

[Rights and Responsibilities](#)  
 Yes, I have reviewed Rights and Responsibilities.

[Authorization for the Disclosure of Protected Health Information](#)  
 Yes, I have reviewed Authorization for the Disclosure of Protected Health Information.

14) Submit the application by clicking on who you are, typing your name, and clicking Submit.

**Submit Application**

By signing the application, you understand and agree to the following:

- I have agreed to submit an application by electronic means.
- I understand that an electronic signature has the same legal effect and enforceability as a written signature on an application.
- I understand that the application must be signed by either the applicant or the legal guardian and can be signed by electronic means. A representative cannot sign the application.
- For purpose of complying with [Neb. Rev. Stat. § 4-109 through 4-114](#), I hereby attest under penalty of perjury, the truth of the information on the application, including the information concerning citizenship and alien status of the members applying for benefits. I 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.
- I understand and agree that DHHS may contact other persons, employers, financial institutions or organizations to obtain the necessary proof of my eligibility.
- When signing this application, I am also signing the Authorization for Disclosure of Protected Health Information. By signing the Authorization for Disclosure of Protected Health Information:
  - I authorize the Department of Health and Human Services to contact and request records and information from doctors and schools for whom I have provided contact information.
  - I acknowledge that the information to be released may include material that is protected by Federal or State law, including benefit or enrollment information; protected health information that may include Drug/Alcohol, HIV, or sickle cell anemia related information. My signature authorizes release of all this 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 or entity, or otherwise, and 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.
  - I understand the advantages and disadvantages and freely and voluntarily give permission to release specific information about the applicant. I also understand that I am not required to disclose the applicant's social security number, though disclosure may make it easier or quicker for information to be provided.
- I understand my responsibilities and agree to fulfill them.
- I understand I may have to provide proof of what I have said. If written proof is not available I agree to give the name or organization so that the Department of Health and Human Services may obtain the necessary proof.
- I will cooperate fully with State and Federal personnel in a Quality Control Review.
- I authorize the release of the Social Security Numbers provided on this application to Department of Health and Human Services.

Who is completing this application?

I am the applicant  
 I am the parent  
 I am the guardian

Sign by typing your name below (this is your electronic signature).  
John Doe

To receive an e-mail confirmation, enter your e-mail address below.  
example@domain.com

If you are someone other than the applicant, your information should match that of someone entered in step 10 of this document.

15) You will receive a confirmation number for your application. Click on Print and be sure to save this number.

**DD Application**

Print

**Confirmation**

**Your application for DD Services has been submitted.  
This is your Confirmation Number:**

**1732831**

**It is important that you keep this number.**

**This is the Electronic Signature for your application:  
1951phrWHYyLc0mHekLI22iB8s00acI**

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Print this page so you can refer to your application number if you call with questions.

Select this link to either [View/Print Application](#) or you can contact DHHS to provide you with a copy of the application.

If you are not registered to vote where you live and would like to register, you can print a [voter registration form](#).

\* EXIT