NOTE: Applications are submitted by the dialysis center social worker.

Before submitting, ensure:

☐ The application is filled out completely (no empty lines or boxes).

☐ A copy of the client’s most recent FEDERAL income tax return showing the Adjusted Gross Income OR Social Security Administration (SSA) benefit statement is included. If applicable, include any retirement/pension benefit statement(s) as well. *If married, the spouse’s income source(s) must also be submitted. If the client can be claimed as a dependent on someone else’s Income Tax Return, their income sources must also be provided.*

☐ The client has signed/dated – and checked the appropriate box – on the U.S. Citizenship Attestation Form as required by Neb. Rev. Stat. §§ 4-108 through 4-114. *If the qualified alien box is checked, also provide a LEGIBLE copy of the front and back of the client’s USCIS documentation when submitting the application.*

☐ If the client’s future income will change significantly, include an explanation why on page 5 and provide documentation. If other areas of the application require greater detail, it can also be captured on page 5. Otherwise, write “Not Applicable” on page 5.

☐ The client has read, signed and dated the release of information and affirmation on page 6.

☐ The doctor has signed the medical certification form on page 7.

The Nebraska Chronic Renal Disease Program cannot make a determination on a client’s application until all items noted above are completed and sent it.

When complete, FAX the form to (402) 742-1118.

If you have questions, email dhhs.renal@nebraska.gov or call (402) 471-0925.

February 2020
Nebraska Chronic Renal Disease Program Application

Please print legibly!
When complete, fax to: (402) 742-1118

Application Date: ___________________________

Client Information

Name: ____________________________________________________________________________
  (Last) (First) (MI)

Street Address: _____________________________________________________________________

City, State, Zip: ____________________________________________________________________

*SSN: _____________________ Birthdate: ___________________ Phone: _______________________

Marital Status: ___________________ **Race: ___________________ (M | S | D | W) (African American | Asian | Caucasian | Hispanic | Native American | Other: List)

Gender:           Female                 Male
  (Circle One) (Circle One)

Veteran Status: Yes       No
  (Circle One)

Employment Status:     Disabled               Employed                   Retired                   Unemployed
  (Circle One)

*It is mandatory to provide your SSN. All information provided to the Program is confidential and will not be used for any other purpose than to determine client eligibility. **For statistical purposes only.

Dialysis Center | Doctor | Social Worker

Dialysis Center Name: ______________________________________________________________

Dialysis Center Address: ________________________________________________________________________________

City, State, Zip: ______________________________________________________________________________________

Name of Nephrologist: ______________________________________________________________

Name of Social Worker (SW): ________________________________________________________________

SW Phone #: _________________________________ SW Fax #: _____________________________

SW Email: __________________________________________________________________________

Nebraska Chronic Renal Disease Program Application | February 2020
(Discontinue use of all previous versions.)
Client Name: _________________________________

**Income**

Submit a copy of the most recent FEDERAL Income Tax Return showing the Adjusted Gross Income OR a copy of the most recent Social Security Administration (SSA) benefit statement.

If applicable, include any retirement or pension benefit statement(s) as well.

**Important:**
- If married, your spouse’s income source(s) must also be submitted.
- If you are claimed as a dependent on someone else’s Income Tax Return, their income sources must also be provided.

Total of last year’s income: __________________________________________________________

*If future income will change significantly, include a one-page statement why on page 5 and provide documentation.*

☐ Check if you did not file an Income Tax Return. Briefly explain why: ______________________________________________________________

Are you claimed as a dependent on someone else’s Income Tax Return?  ☐ Yes ☐ No

If yes, whose? _________________________________________________________________

Do you have relatives legally responsible to provide care and treatment for you who refuse to provide such care and treatment?

☐ Yes ☐ No

If yes, note whom and relationship: ____________________________________________

Within the past two years, have you given away – or sold for less than fair market value – any property?

☐ Yes ☐ No

If yes, note the type of property, the value of the poverty and why: __________________________

_________________________________________________________________________________

**Household**

Family members living in the home during the past year:

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Relationship</th>
<th>Employed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>☐ Yes ☐ No</td>
</tr>
</tbody>
</table>

Nebraska Chronic Renal Disease Program Application | February 2020
(Discontinue use of all previous versions.)
Page 2 of 7
Client Name: _________________________________

### Health Insurance

Do you have private health insurance?  □ Yes  □ No

If yes, provide the following information:

<table>
<thead>
<tr>
<th>Insurance Company Name</th>
<th>Type of Coverage</th>
<th>Effective Date</th>
<th>Policy Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Do you have Medicare?  □ Yes  □ Yes, pending  □ No  □ No, but have applied

If yes, provide the following information:

<table>
<thead>
<tr>
<th>Type of Coverage (check each box that applies)</th>
<th>Effective Date</th>
<th>Medicare ID Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Part B  □ Part C  □ Part D</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Any other Medicare plans? If yes, list:

Do you have Medicaid?  □ Yes  □ Yes (Share of Cost)  □ No  □ No, but have applied

If yes, provide the following information:

<table>
<thead>
<tr>
<th>Medicaid ID Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>
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

__________________________
Client Name: _________________________________

Use this page to indicate if future income will change significantly (due to death of a family member, disability status, inability to work, etc.) or if other areas of the application require greater explanation. Do not exceed one-page. **Documentation is required to substantiate income explanations.** For example, a letter from a past employer, a letter from your doctor stating your inability to work as a result of your illness, etc.
Client Name: ______________________________________

**Release of Information**

The following people have permission to contact the Nebraska Chronic Renal Disease Program and discuss your renal-related condition and/or application and renewal requirements:

<table>
<thead>
<tr>
<th>Name</th>
<th>Year of Birth</th>
<th>Relationship to You</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The consent to release information may be revoked by you at any time by informing the Renal Program in writing. If left blank, your case will not be discussed with anyone but your renal social worker, your service providers or you.

Initial your understanding: ______________________________________

Date: ____________________________

**Affirmation**

I, the undersigned, hereby authorize the release of information requested from me to the Nebraska Department of Health and Human Services.

The information will be used to determine my eligibility for assistance from the Nebraska Chronic Renal Disease Program.

Further, if approved, it is understood that the Program only assists with the cost of pharmaceuticals and dialysis, and **does not pay** the expenses of any other illness. In accordance with 181 NAC 1, payment for services will be provided as long as current state appropriations are available and I continue to meet the Program eligibility requirements.

I affirm that the information provided in this application is true, complete and accurate.

_________________________________________________________________________________

Client Signature

_________________________________________________________________________________

If client is under 19 years of age, Parent or Guardian signature is required.

Date: ____________________________
Medical Certification

Client Name: _________________________________

Diagnosis: __________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Recommended Therapy: ______________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Date of First Dialysis Treatment: _________________________________________________

Transplant Date: _____________________________________________________________

The client meets the criteria for chronic renal disease. □ Yes □ No

Check one:    □ NEPHROLOGIST    □ PA    □ APRN

Signature: __________________________________________________________________

Printed Name: _______________________________________________________________

Address: ___________________________________________________________________

City, State, Zip: ______________________________________________________________

Telephone: _________________________________________________________________

Date: ______________________________________________________________________
This notice is provided as required by Title II of the Americans with Disabilities Act of 1990 (ADA) and Section 504 of the Rehabilitation Act of 1973 (Sec. 504), and Section 1557 of the Affordable Care Act (ACA/Sect. 1557).

The Nebraska Department of Health and Human Services (DHHS) is committed to providing equal access to employment, programs, service, activities and benefits to qualified individuals with disabilities. DHHS complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, sex, or disability in admission to its programs, services, or activities; in access to them; in treatment of individuals with disabilities; in provision of benefits, in its hiring or employment practices, or in any aspect of their operations.

DHHS will generally, upon request, provide appropriate aids and services leading to effective communication for qualified individuals with disabilities so that they can participate equally in DHHS’s programs, services and activities. This includes qualified sign language interpreters, written information in other formats (large print, audio, accessible electronic formats, and other formats). Free language services are available to people whose primary language is not English, such as qualified interpreters and information written in other languages. Any individual who requires an auxiliary aid or service for effective communication related to any DHHS program, service or activity should contact the ADA, Sec. 504, and ACA/Sec. 1557 Compliance Coordinator.

DHHS will make reasonable modifications to policies and programs to ensure that individuals with disabilities have an equal opportunity to enjoy all of its programs, services, activities, and benefits. Any individual who requires a modification to a policy or program should contact the ADA, Sec. 504, and ACA/Sec. 1557 Compliance Coordinator.

Any complaint that a DHHS program, service or activity is not accessible to individuals with disabilities, or has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, should be directed to the ADA, Sec. 504, and ACA/Sec. 1557 Compliance Coordinator. You can file an ACA/Section 1557 complaint in person or by mail, fax, or email. If you need help filing a complaint the ADA, Sec. 504, and ACA/Sec. 1557 Coordinator is available to help you.

The ADA and ACA do not require DHHS to take any action that would fundamentally alter the nature of its programs or services, or impose any undue financial or administrative burden upon DHHS. Questions, complaints or requests for additional information regarding the ADA, Section 504, and ACA/Sec. 1557 may be forwarded to the designated ADA, Section 504, and ACA/Section 1557 Compliance Coordinator:

Grant Dugdale, ADA, Sec. 504, and ACA/Sec. 1557 Compliance Coordinator
Nebraska Department of Health and Human Services
301 Centennial Mall South
Lincoln, NE 68509
Phone: (402) 471-7242

You can also file a complaint with the U.S. Department of Health and Human Services, Office of Civil Rights electronically through the Office of Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal_lobby.jsf, or by mail or phone at:
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

This notice is available in large print or in audio by contacting the ADA, Sec. 504, and ACA/Sec. 1557 Coordinator.
English
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-722-1715 (TTY: 402-471-9570 or 711 or 1-800-833-7352).

Spanish
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-722-1715 (TTY: 402-471-9570 or 711 or 1-800-833-7352).

Vietnamese
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-722-1715 (TTY: 402-471-9570 or 711 or 1-800-833-7352).

Chinese
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-722-1715 (TTY: 402-471-9570 or 711 or 1-800-833-7352).

Arabic
بالمجان. اتصل برقم ملاحظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوفر لك. 1 -800-722-1715 (رقم هاتف الصم (والبكم: TTY: 402-471-9570 or 711 or 1-800-833-7352).

Karen
1-800-722-1715; (TTY: 402-471-9570 or 711 or 1-800-833-7352).

French
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-722-1715 (ATS : 402-471-9570 or 711 or 1-800-833-7352).

Cushite

German