



DHHS Metabolic Foods Program Financial Hardship Waiver Application

1) **Name of Applicant** (medically requires pharmaceutically manufactured food):

2) **Name of any family member who will be ordering food** (if other than the applicant):

3) **Select one of the following:**

Applicant is currently enrolled in Medicaid.
(Medicaid status will be confirmed by the DHHS Metabolic Foods Office)

OR

The applicant does not have Medicaid, but has a household income of no more than 185% of the Federal Poverty level (see chart on the back of this page)

AND

Included are copies of all paychecks or income from the last 30 days OR a copy of the most recent years tax return.

This household supports _____ child(ren) under age 19.

Signature: _____ **Date:** _____

*By signing this form I attest or affirm the above information is truthful

*If approved, applicant qualifies for the Financial Hardship waiver until June 30, 2018

Return in one of the following ways:

Mail: DHHS – Newborn Screening Program

PO Box 95026

Lincoln, NE 68509-5026

Fax: (402)742-2332

Email: dhhs.newbornscreening@nebraska.gov

Office Use Only

Date Received: _____

Approved (initial/date): _____

Denied (initial/date): _____

Notification Date: _____

2017-2018 Income Guidelines

Household Size	Annual	Monthly	Twice Monthly	Bi-weekly	Weekly
1	\$22,311	\$1,860	\$930	\$859	\$430
2	\$30,044	\$2,504	\$1,252	\$1,156	\$578
3	\$37,777	\$3,149	\$1,575	\$1,453	\$727
4	\$45,510	\$3,793	\$1,897	\$1,751	\$876
5	\$53,243	\$4,437	\$2,219	\$2,048	\$1,024