

# Disabled Persons and Family Support Disability Report



**Section I:**  
**To Be Completed By The Applicant/Patient Or Applicant's Representative**  
**Before Submitting To The Physician, Physician Assistant, Licensed Nurse or Other Health Professional**

To:

Address

From: Applicant's Name	Social Security Number	Birthdate
Mailing Address	City	Zip Code
Name of Representative for the Applicant/Relationship	Representatives Phone Number	
Mailing Address	City	Zip Code

I am applying for assistance through the Disabled Persons and Family Support Program which is administered by the Nebraska Department of Health and Human Services. This medical report is required to verify my need for:

(List specific services from Page 1 of the application)

My application for this program will not be complete until this report is received. I will submit it to the Program, or, if you prefer, you have my consent to send it to:

DPF Support Program  
P.O. Box 95044  
Lincoln, Nebraska 68509-5044

If there is a charge for completion of this form, bill me privately.

Applicant's Signature	Date
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**THE REVERSE SIDE OF THIS FORM MUST BE COMPLETED**

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**SECTION II:  
Physician, Physician Assistant, Licensed Nurse or Other Health Professional**

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Please give a brief statement INCLUDING DIAGNOSIS and add any comments you may care to make :

**\*\*\* DPF SUPPORT DEFINES DISABLED AS:**

- 1) The applicant is at risk of having to move to a care facility due to severe, chronic limitations; and
- 2) The applicant's disabling condition requires constant supervision and/or constant assistance with personal care needs.

In your opinion, does this applicant meet the disability requirements given above, AND, is the disability likely to continue indefinitely?

- NO, this person does not meet the above definition of disabled for the following reason(s):
- YES, this person does meet the above definition of disabled. This disability causes substantial functional limitations in the following areas:

Personal/Self Care (List specifically):

Mobility (List specifically):

**Person Needs Assistance with:**

- | <b>Yes</b>               | <b>No</b>                |                                   | <b>Yes</b>               | <b>No</b>                |                                 |
|--------------------------|--------------------------|-----------------------------------|--------------------------|--------------------------|---------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Self Direction                    | <input type="checkbox"/> | <input type="checkbox"/> | Economic Sufficiency            |
| <input type="checkbox"/> | <input type="checkbox"/> | Work Skills or Work Tolerance     | <input type="checkbox"/> | <input type="checkbox"/> | Personal Self Care              |
| <input type="checkbox"/> | <input type="checkbox"/> | Receptive and Expressive Language | <input type="checkbox"/> | <input type="checkbox"/> | Mobility                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Learning                          | <input type="checkbox"/> | <input type="checkbox"/> | Capacity for Independent Living |

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Signature of Health Professional

Date

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Office Address