



Service & Device Application (Multi-Agency Form)

Date	Assisting with this form, i.e. Parent/Guardian/Representative		
Applicant/Person with Disability	Name		
Name (First, Middle, Last)	Relationship to applicant		
<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Miss	Address		
Address	City	State	Zip Code
City	State	Zip Code	Phone
County	E-mail		
Home Phone	Referral Source		
Work Phone	Name		
E-mail	Agency/Organization		
Date of Birth	Address		
Social Security Number	City	State	Zip Code
What is your disability?	Phone		
	E-mail		
	Case Manager or Services Coordinator		
How does your disability impact your daily living activities?	Name		
	Agency/Organization		
	Phone		
	Name		
	Agency/Organization		
	Phone		
Household Members	Name - Relationship to applicant (e.g., spouse, son, daughter, attendant, guardian, etc.)		Date of Birth
List the services and devices you are requesting. List the most important first.			Estimated cost (if known)

Services and Devices Requested (check all that apply)	Personal (check all that apply)
<input type="checkbox"/> Home Modifications <input type="checkbox"/> Purchase or refinance a home <input type="checkbox"/> Personal attendant <input type="checkbox"/> Meals and lodging <input type="checkbox"/> Home health care <input type="checkbox"/> Housekeeping service <input type="checkbox"/> Prescriptions <input type="checkbox"/> Respite care <input type="checkbox"/> Special equipment/assistive devices <input type="checkbox"/> Transportation <input type="checkbox"/> Other _____	Veteran Status <input type="checkbox"/> Veteran ___ The person with a disability is a veteran ___ The spouse of applicant with a disability is a veteran ___ The parent of applicant with a disability is a veteran <input type="checkbox"/> Veteran was in military service during a war <input type="checkbox"/> Veteran has a service-connected disability <input type="checkbox"/> Veteran is a resident of Nebraska Dates of service _____
Housing (check all that apply) <input type="checkbox"/> Home Owner <input type="checkbox"/> Renter Landlord _____ Address _____ City/State/Zip _____ Phone _____ <input type="checkbox"/> Nursing home <input type="checkbox"/> Foster home/adult family home <input type="checkbox"/> Group home/community residence <input type="checkbox"/> Living with adult/adult children <input type="checkbox"/> Homeless <input type="checkbox"/> Other _____	Are you registered to vote? <input type="checkbox"/> Yes <input type="checkbox"/> No
Type <input type="checkbox"/> Single Family Unit <input type="checkbox"/> Multi-family unit – number of units _____ <input type="checkbox"/> Mobile home <input type="checkbox"/> Other _____	Insurance <input type="checkbox"/> Health Insurance Specify _____ <input type="checkbox"/> Medical Assistance/Medicaid <input type="checkbox"/> Medicare
Assistance received from: <input type="checkbox"/> League of Human Dignity, Barrier Removal Program <input type="checkbox"/> Housing and Urban Development, Section 203 <input type="checkbox"/> Making Homes Accessible (MHA) <input type="checkbox"/> Rural Development, Section 502 <input type="checkbox"/> Rural Development, Section 504 <input type="checkbox"/> Weatherization <input type="checkbox"/> HomeChoice	Assistance Check any of the following that have provided assistance to you (i.e. information, referral, or funding) during the last year: <input type="checkbox"/> Area Agency on Aging <input type="checkbox"/> Hotline for Disability Services <input type="checkbox"/> Independent Living Center <input type="checkbox"/> Nebraska Assistive Technology Partnership <input type="checkbox"/> Nebraska Commission for the Deaf and Hard of Hearing ___ Assistive listening devices ___ Decoder loan ___ Hearing aid bank ___ TDD loan <input type="checkbox"/> Nebraska Educational Assistive Technology (NEAT) <input type="checkbox"/> Nebraska Health and Human Services ___ Developmental Disabilities ___ Disabled Persons and Family Support ___ Aged & Disabled Medicaid Waiver ___ Medically Handicapped Children's Program ___ Mental health services ___ Social Services Block Grant <input type="checkbox"/> Nebraska Veterans' Aid Fund <input type="checkbox"/> Paralyzed Veterans of America Education Center <input type="checkbox"/> United Cerebral Palsy of Nebraska <input type="checkbox"/> Veterans Service Office <input type="checkbox"/> Vocational Rehabilitation <input type="checkbox"/> Other _____
United States Citizenship Attestation - For the purpose of complying with neb. Rev. Stat. §§ 4-108 through 4-114, I attest as follows: <input type="checkbox"/> I am a citizen of the United States OR <input type="checkbox"/> I am a qualified alien under the federal Immigration and Nationality Act, my immigration status and alien number as follows: _____	

Financial Information

List the amount of income you receive (i.e. your family) from each of the sources below. Single adults (19 years of age or older with no minor children) should list only your income. Families should list income of married couples or income of all adults, including wages of children ages 14–18.

Gross Income (your income before deductions)	Amount	How often received	Who receives it
Wages, overtime, bonuses, commissions, etc.			
Self-employment (use current IRS 1040)			
Interest dividends, money from investments and capital gains)			
Social Security Retirement			
Social Security Income (SSI)			
Social Security Disability Insurance (SSDI)			
Veteran's Benefits			
Pensions			
Retirement, Keogh Accounts, IRAs, etc.			
Inheritance, estates, trust funds, etc.			
Aid to Aged, Blind and Disabled (State Supplement Check)			
Temporary Assistance to Needy Families (TANF)			
Alimony/Child Support			
Compensation (worker's and unemployment)			
Rental income and boarders			
Miscellaneous (insurance settlements, lottery winnings, and other, please describe)			
Assets List assets that are readily available (e.g. cash, checking accounts, stocks, bonds, whole life insurance, certificates of deposit, farmland, etc. and any liquid assets that can be converted to cash without incurring a substantial tax penalty for early withdrawal)			Amount
Expenses related to your disability (e.g. medication, doctor bills, transportation to the doctor, special equipment, etc.)			Amount

Release/Agreement Form

I verify that the information provided on this application is correct and complete.

I understand that whenever changes occur in the information provided, I need to report them immediately to one of the agency/agencies helping me obtain devices or services.

I understand I have the right to appeal if I am not satisfied with an agency's action.

I understand that this is a **multi-agency form**. The agencies/programs listed below may contact each other to determine my financial eligibility for their programs, and may verify my need for the support for which I have applied. I authorize the release of this information to be used for referrals/services for which it is determined I may be eligible. It is my understanding that this information will be held confidential by all the agencies listed.

- Client Assistance Program
- Hotline for Disability Services
- Independent Living Centers
- Making Homes Accessible (MHA) Program
- Muscular Dystrophy Association
- Nebraska Advocacy Services
- Nebraska Assistive Technology Partnership
- Nebraska ChildFind
- Nebraska Commission for the Blind and Visually Impaired
- Nebraska Commission for the Deaf and Hard of Hearing
- Nebraska Department of Health and Human Services
- Nebraska Easter Seal Society
- Nebraska Department of Veterans' Affairs, Nebraska Veterans' Aid Fund
- Nebraska Housing Developers Association and Home Ownership Program
- Paralyzed Veterans of America Education Center
- The Arc of Nebraska
- United Cerebral Palsy of Nebraska
- US Department of Agriculture (USDA)
- Vocational Rehabilitation
- Other _____

Information may be released and shared on my behalf with the following family members and individuals:

Signature of applicant (or guardian) _____ Date _____

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.

Signature of applicant (or guardian) _____ Date _____

The following information is being requested for Federal reporting purposes only. Your response is optional and will not affect your eligibility determination. We would appreciate your assistance by providing a response.

Ethnicity/race (please check)

- White (non-Hispanic) Black (non-Hispanic) American Indian or Alaskan Native Asian or Pacific Islander
 Hispanic Multi-Racial Other

Return this form to: Department of Health and Human Services
Medicaid and Long-Term Care
Disabled Persons and Family Support
PO Box 95026
Lincoln, NE 68509-5026

If you have questions about this form call:
Lincoln **(402) 471-9220** or
Toll Free **(800) 358-8802**