To: Name
address
city, state zip+4

From: Developmental Disabilities Division

Date:

RE: Inquiry into DD Services

Your inquiry on services through the Division of Developmental Disabilities has been received. In order to determine your eligibility for services, additional information is needed. If you are interested in requesting a determination of eligibility by the Division, please carefully review this letter and enclosures.

The Division will only review applications that include a complete and signed application form, with all required records/documents. Required documents/records are listed within this letter, and a checklist is enclosed to assist you in gathering all required records/documents for your application. No action will be taken by the Division of Developmental Disabilities unless the completed & signed application including all required documents/records are received by the office noted below:

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

Application process for DD Eligibility
Documents/records listed below are to be submitted as part of the application for DD Services.

Forms that need to be completed and returned with appropriate records are:

- Completed application form (enclosed) which is signed/dated by the applicant or his/her court-appointed guardian
- Completed "United States Citizenship Attestation Form" (enclosed)
- Enclosed "Rights and Obligations" form signed and dated by applicant (parents if a minor or applicant's court-appointed guardian)

Copies of the following documents need to be submitted if they apply to this applicant:

- Copy of court-appointed guardianship papers (if applicant is 19 yrs or older and has a court-appointed guardian)
- Reports/notifications from the Social Security Administration for SSI disability determination and notice of Disability Determination and Transmittal, form SSA 831-C3

If assessments have been completed for the applicant, please submit reports or summaries of results for assessments of intellectual and/or adaptive behavioral functioning:

- **Summary of Results** of IQ tests/Assessment(s) of intellectual functioning. Examples of this type of assessments include, but are not limited to: *Wechsler Scale of Intelligence for Children (WISC); Wechsler Scale of Intelligence for Adults (WAIS); Kaufman Brief Intelligence Test (KBIT); Stanford-Binet; Comprehensive Test of Nonverbal Intelligence (CTONI); Test of Nonverbal Intelligence (TONI)*
- **Summary of Results of** Assessment(s) of adaptive behavioral functioning. Examples of this type of assessments Include, but are not limited to: *Scales of Independent Behavior – Revised (SIB-R); Vineland Adaptive Behavior Scales; Adaptive Behavior Assessment Scales (ABAS)*

If the applicant's current or previous medical diagnoses prior to age 22 have affected his/her ability to carry out activities of daily living skills, please submit related physician reports/diagnoses.

- Documentation by a physician of Diagnoses (i.e. medical, genetic syndrome/disorder) Current medications, including both prescribed and over-the-counter (include purpose of medication, dosage, and frequency of administration)
- Hospitalization admission and discharge records if related to significant injuries or conditions limiting the applicant's ability to carry out activities of daily living skills.
- Medical history if there is a medical reason for a decline or a disability (i.e. major illnesses, surgeries/hospitalizations, brain injury, and other pertinent medical history)

If the applicant current or previous psychiatric diagnoses prior to age 22 have affected his/her ability to carry out activities of daily living skills, please submit related psychiatric reports/diagnoses or psychological reports.

- All Psychiatric evaluations (if a psychiatric diagnosis and when an evaluation rules out a psychiatric diagnosis)
- Records of psychotherapy or counseling (if individual is receiving or has received psychotherapy or counseling)
- Psychiatric hospitalizations (i.e., admission and discharge paperwork, if previous psychiatric hospitalizations)
- Current and previous medications, including both prescribed and over-the-counter (include purpose of medication, dosage, and frequency of administration)

If there has been contact with the legal system, provide documentation (e.g., police contact, formal charges, convictions, and sentencing – include community service, probation, jail time, parole, etc.)

Other information that may apply to the applicant:

- All Multi Disciplinary Team (MDT) reports and most recent Individual Education Plan (IEP)
- Evaluations or reports of evaluations completed by vocational rehabilitation (if individual has been evaluated or evaluated and served by vocational rehabilitation)

The enclosed consent forms are provided for obtaining Social Security, psychiatric, and/or counseling records that can only be released directly to the Division – these forms should be completed, signed and sent **BY YOU** to each provider or source of records).

Upon receipt of a completed signed application with all required and applicable accompanying records and documents, the Division will review and evaluate items received.

Enclosures:
Application for Services
Eligibility Criteria (for your reference)
United States Citizen Attestation Form
Consent Form(s)(for requesting records directly from agencies or providers)
Notice of Rights and Obligations
Checklist of required documents/records (for applicant's use, do not return to the Division)

Department of Health & Human Services
DHHS
NEBRASKA

Division of Developmental Disabilities Application

Answer each question below by checking the response that applies to you

Did your disability occur before the age of 22? Yes ☐ No ☐

Do you have a diagnosis of mental illness? Yes ☐ No ☐

First Name:_____ Middle Name:_____ Last Name:_____

List any previous names used, including maiden name, if applicable:_____

Birth date:_____ SSN:_____ Phone: ( )_____ Gender:_____

Address:_____ City:_____ Zip:_____

Mailing Address (if different):_____ City:_____ Zip:_____

I am a United States Citizen Yes ☐ No ☐

Place of birth:_____

I am a qualified alien under the Federal Immigration & Nationality Act Yes ☐ No ☐

Alien Number:_____ Immigration Status:_____

I am a legal resident of Nebraska Yes ☐ No ☐

I am a state ward. Yes ☐ No ☐ *If yes, fill in requested information under legal guardian in next section*

I am a minor child, under the age of 19 years old & living with my natural guardian. Yes ☐ No ☐

I am in a subsidized adoption. Yes ☐ No ☐ (list only information regarding adoptive parent/s below)

If parents are not living together, list custodial parent information first

Parent Name/s:_____ Date of birth:_____

Address (if different from mine): _____

City: _____ Zip: _____ Home Phone: ( )_____

Parent Name/s:_____ Date of birth:_____

Address (if different from mine): _____

City: _____ Zip: _____ Home Phone: ( )_____

I have a legal guardian Yes ☐ No ☐ *If no, proceed to the next section*

Name:_____

Address:_____ Town:_____ Zip:_____

Name:_____

Address:_____ Town:_____ Zip:_____

If you have additional legal guardians, please list information requested above on a separate sheet and attach.

Do you currently receive money or services from the following sources? Check all that apply.
If no, proceed to the next section.

	Applied	Date Applied	Receiving	Frequency
Social Security	Yes ☐ No ☐	_____	Yes ☐ No ☐	_____
SSI	Yes ☐ No ☐	_____	Yes ☐ No ☐	_____
Medicaid	Yes ☐ No ☐	_____	Yes ☐ No ☐	_____
Medicare	Yes ☐ No ☐	_____	Yes ☐ No ☐	_____
Workers Compensation	Yes ☐ No ☐	_____	Yes ☐ No ☐	_____
Railroad/other Retirement	Yes ☐ No ☐	_____	Yes ☐ No ☐	_____
Insurance/ Accident Settlement	Yes ☐ No ☐	_____	Yes ☐ No ☐	_____
Vocational Rehabilitation	Yes ☐ No ☐	_____	Yes ☐ No ☐	_____
Other	Yes ☐ No ☐	_____	Yes ☐ No ☐	_____

Are you currently receiving Medicaid waiver services from the Aged & Disabled waiver? Yes ☐ No ☐

If there is any other information relevant to this application that you want us to know, note it here. *If none, proceed to the next section.*

If you are not registered to vote where you live now, would you like to apply to register to vote?

Yes ☐ No ☐

Please tell us who is completing this application:

I am the applicant:_____

I am a legal guardian for the applicant:_____

I am a person legally authorized to act on behalf of the applicant – please enter your name and your relationship to the applicant.

_____

The applicant for DD services(or his/her legal representative) must sign this application.
If the applicant is a minor child, the parent(s) signature is required.
If the applicant is a state ward or has a legal guardian, the signature of the legal guardian is required.

_____ _____

Signature Date

Eligibility will be based on the following definition of developmental disability:

1. Mental retardation; or
2. A severe, chronic disability other than mental retardation or mental illness which:
    a. Is attributable to a mental or physical impairment other than a mental or physical impairment caused solely by mental illness;
    b. Is manifested before the age of twenty-two years;
    c. Is likely to continue indefinitely; and
    d. Results in:
        1. In the case of a person under 3 years of age, at least one developmental delay; or
        2. In the case of a person 3 years of age or older, a substantial limitation in three(3) or more of the following areas of major life activity, as appropriate for the person's age:
            a. Self-care;
            b. Receptive and expressive language development and use;
            c. Learning;
            d. Mobility;
            e. Self-direction;
            f. Capacity for independent living; and
            g. Economic self-sufficiency (children under age 18 are not assessed in this area).

Reference Nebraska Revised State Statute 83-1205

Department of Health & Human Services
DHHS
NEBRASKA

Division of Developmental Disabilities
NOTICE OF RIGHTS AND OBLIGATIONS

Name: _____ Date of Birth: _____ NFOCUS Person Number: _____

Notice of Rights

As a person who has requested developmental disabilities services, I understand that I have the following rights:

- **The right to have action initiated on my request within 45 days of the date of the Division's receipt of the application and requested information. If feasible, the action on my request will be completed within that time period.**
- **The right to receive written notice of any decision, any termination, or change of previously authorized services.**
- **The right to file an appeal in writing of any decision or action and to have a fair hearing on my appeal. I understand that I must appeal within 90 days of the date of any Notice of Decision that I receive.**

Notice of Obligations

I have been informed of and I understand and agree to the following obligations:

- **I understand that no action will be taken by the Division when no information is received.**
- **I must apply for and accept all benefits that I may be eligible to receive, which may include SSI, SSA, Nebraska Medicaid, and Home & Community-Based waiver services. I agree to take action to maintain eligibility for all benefits that I may be eligible to receive.**
- **I must pay the amount of my Medicaid share of cost obligation to my DD provider monthly when I am informed of the obligation.**
- **I must complete and submit required information prior to starting DD funded services, annually, or as requested. This may include benefit and resource information or a copy of my tax returns for the determination of my ability to pay for community-based developmental disabilities services.**
- **I must participate in any assessments or evaluations required to maintain my services, which include, but are not limited to psychological, annual medical, and dental evaluation(s), as well as the Objective Assessment Process.**

I have been informed that failure to fulfill the above obligations may result in denial or termination of funding for developmental disabilities services.

_____

Signature (Individual/Parent of a minor child/legal guardian) Date

_____

Signature (DHHS staff providing information) Date

Original: Individual File Copy: Individual/Parent of a minor child/legal guardian

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 _____

Department of Health & Human Services
DHHS
NEBRASKA

Division of Developmental Disabilities

State of Nebraska
Dave Heineman, Governor

I give my consent for _____
to release the confidential information described below regarding_____
_____ to the Nebraska Health & Human Services Developmental Disabilities System Service Coordination staff. I also release the person or entity identified above from any liability for releasing the information identified below. I give permission for the following information to be released:_____

_____

_____

_____

_____

This release is made for the purpose of: **Determination of eligibility for Division of Developmental Disabilities services/funding.**

This authorization for release of information will remain valid until _____. (Not to exceed one year from the date it is signed.) This release may be revoked at any time by written notice to Developmental Disabilities System Service Coordination staff.

Recipient should mail the consent & copies of all material requested to:

Division of Developmental Disabilities
NSOB, 3rd floor
PO Box 98947
Lincoln, NE 68509-8947

Or FAX to: Division of Developmental Disabilities 402/471-8792

The recipient will view a photocopy or faxed copy of the original signed consent as the original.

_____ _____
Signature of Individual or Guardian Date

_____
If Guardian, Relationship to Individual

_____ _____
Witness Date

_____ _____
Witness Date

SAMPLE

Department of Health & Human Services
DHHS
NEBRASKA

Division of Developmental Disabilities

State of Nebraska
Dave Heineman, Governor

I give my consent for _____**Dr. Tom Smith**_____
to release the confidential information described below regarding_**Bob Johnson_(dob 2/15/05)**_
_____to the Nebraska Health & Human Services Developmental Disabilities System Service Coordination staff.

I also release the person or entity identified above from any liability for releasing the information identified below. I give permission for the following information to be released:

All records and reports relating to the diagnosis/treatment of a developmental disability, mental health and/or a behavioral disorder.

This release is made for the purpose of: **Determination of eligibility for Division of Developmental Disabilities services/funding.**

This authorization for release of information will remain valid until ___**7/1/12**_____. (Not to exceed one year from the date it is signed.) This release may be revoked at any time by written notice to Developmental Disabilities System Service Coordination staff.

Recipient should mail the consent & copies of all material requested to:
Division of Developmental Disabilities
NSOB, 3rd floor
PO Box 98947
Lincoln, NE 68509-8947

Or FAX to: Division of Developmental Disabilities 402/471-8792

The recipient will view a photocopy or faxed copy of the original signed consent as the original.

_____ _____
Signature of Individual or Guardian Date

_____
Relationship to Individual, if guardian

_____ _____
Witness Date

_____ _____
Witness Date

Checklist for Gathering Documentation/Records

(Keep this checklist for your reference)

Note: Consent forms (enclosed) are to be used by the applicant or his/her legal guardian for obtaining Social Security, psychiatric, and/or counseling records that can only be released directly to the Division – these forms should be completed, signed and sent **BY YOU** to each source of records. Do not send a consent form to the Division. Make copies if more blank consent forms are needed.

Submit application to the Developmental Disabilities Division once required documentation has been gathered. Once an application is received by a Division, it will be reviewed. If applicants submit an application without all required documents, it will result in a determination that the applicant is ineligible. Applicants may want to send the application and records to the DD Division by a return receipt method or other method that assures delivery to the address below:

Section V – If the applicant current or previous psychiatric diagnoses prior to age 22 have affected his/her ability to carry out activities of daily living skills, please submit related psychiatric reports/diagnoses or psychological reports.

_____ All Psychiatric evaluations (if a psychiatric diagnosis and when an evaluation rules out a psychiatric diagnosis)

_____ Records of psychotherapy or counseling (if individual is receiving or has received psychotherapy or counseling)

_____ Psychiatric hospitalizations (i.e., admission and discharge paperwork, if previous psychiatric hospitalizations)

_____ Current and previous medications, including both prescribed and over-the-counter (include purpose of medication, dosage, and frequency of administration)

Section VI – If the applicant has had contact with the legal system, provide documentation (e.g., police contact, formal charges, convictions, and sentencing – include community service, probation, jail time, parole, etc.)

_____ Documentation related to legal system

Section VII – Documents related to the applicant's assistance through the education system.

_____ All Multi Disciplinary Team (MDT) reports and most recent Individual Education Plan (IEP)

_____ Evaluation record completed by the vocational rehabilitation system

The application with documentation should be submitted to the Developmental Disabilities Division at:

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