

Respite Subsidy Application

Respite Subsidy Program Across the Lifespan

(See instructions on page 3 for assistance)



Section 1 GENERAL INFORMATION

Name of Person with Special Needs			Birthdate	Age
Mailing Address			Social Security Number	
City	County	Zip Code	Telephone	
Caregiver's Name (person residing with above named person as the usual caregiver)			Relationship to Person with Special Needs	

Indicate the total number of people who live in the household of the person with special needs.

Name	Date of Birth	Relationship to person with special needs

Section 2 DISABILITY

- Please describe the person's special needs. Include the person's medical diagnosis, if known. Attach additional sheet, if necessary.

- Explain Caregiver's need for respite (relief time away from caregiving responsibilities).

Section 3 SUPPORT SERVICES

- Are you now receiving any financial assistance for respite? Yes No
If yes: Who pays for the respite? _____
- Is the person with special needs receiving services from: (check all that apply)
 Health Insurance Medicaid Developmental Disabilities System
 If yes: Name of health insurance company _____

Section 4 RESOURCES/ASSETS

List any cash, checking accounts, stocks, bonds, whole life insurance, certificates of deposit, etc., and any assets that can be converted to cash.

Include assets belonging to person with special needs, their spouse and children under 19. If a person with special needs is under 19, include parents and siblings under 19.

Asset	Whose is it?	Amount

Section 5 INCOME

List all gross income (before deductions). Include person with special needs, their spouse and children under 19.
 If person with special needs is under 19, include parents and siblings under 19.

Income Type	Kind of Income	Amount	How Often is it Received	Who Receives it
Wages, Self-Employment				
Assistance Programs (Social Security, SSI, ADC, Veterans)				
Interest, Dividends				
Child Support, Alimony				
Other:				

Section 6 DISABILITY-RELATED EXPENSES

List all disability-related expenses the person with special needs has to pay in a year's time. Do not include amounts covered by insurance or other benefit program(s). Examples of expenses: doctor visits, prescriptions, diapers, medical transportation, wheel chairs, lifts, loans for architectural modification. Do not include expenses of other family members.

What Expense	How Much Cost	How Often	Whose Expense

United States Citizenship Attestation 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: _____

Section 7 AGREEMENT AND SIGNATURE

I understand that my statements may be checked, and if I have given false statements or information, I may be found guilty of fraud.
 I understand that whenever there are any changes in the information I have given, I must immediately report them to the Nebraska Department of Health & Human Services, Respite Case Manager.

I understand that if I do not think my request is handled correctly, I have the right to file an appeal.

I understand that the Nebraska Department of Health and Human Services may need to contact other agencies and individuals to determine my financial eligibility and to verify my need for the support for which I am applying, or to make referrals to assist me in obtaining services. I authorize the release of this confidential information.

Payments for benefits may be delayed if you did not complete Social Security number for person with special needs.

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 Person with Special Needs or Parent or Guardian		Date Signed	
Signature of person Who Helped Complete this Application, if applicable		Date	
Address	City	State	Telephone

Send completed application to: Nebraska Department of Health & Human Services
 Medicaid & Long Term Care State and Grant Funded Programs
 P.O. Box 95026
 Lincoln, NE 68509-5026
 Questions? Call toll-free: 1-800-358-8802 or in Lincoln: 471-9509

Instructions:

Instructions for completing Form MILTC-1400, "Respite Subsidy Program Application, Respite Subsidy Program Across the Lifespan"

Use: Form MILTC-1400 is used as an application for Respite Subsidy Program benefits. The Respite Subsidy Program worker will use the form to collect data needed to determine eligibility for respite services. It also serves as a release of information when additional information is needed to determine eligibility.

Completion: The Respite Subsidy Program worker will use the data to determine eligibility. The application must be signed and dated by the client or his/her representative.

Identifying Information: Enter the name, address, telephone number, Social Security number and date of birth of the person with special needs. Also enter the name and Social Security number of the caregiver. Tell how the caregiver is related to the person with special needs.

Family Size/Persons Living in Household: This information is needed to determine legal financial responsibility. Enter name, date of birth, and relationship to person with special needs.

Disability: This information is used to determine if the person with special needs qualifies for the Respite Subsidy Program. It may be used to establish priorities and waiting lists. It also tells about the caregiver's needs. Please explain how the individual's special need impacts his/her daily life.

Support Services: This information helps to identify other services/referrals that may be more appropriate than Respite Subsidy Across the Lifespan. It is a factor of eligibility.

Resources/Assets: List any liquid resources including cash on hand, checking and savings accounts, certificates of deposit, stocks, bonds, life insurance cash values, IRA and Keogh Funds, etc., This data will be used as another point of eligibility. Income: List all income of any kind, List the gross amount received before any deductions are made.

Disability-Related Services: Information listed here will be considered to see if the expense may be disregarded from the income. It should include things such as out-of-pocket expenses for prescriptions, home modifications, diapers for individuals above age 3, etc.,

Attestation Completion: Check either US citizen or qualified alien box for the individual with special needs. If the qualified alien box is checked provide your immigration status and alien number. Enter the name of the individual with special needs. Sign the form, if the individual is not able to sign then the individual's parent/guardian or representative may sign the form.

Signature/Date: The person with special needs or authorized representative must sign the application before we can authorize benefits.

Mail: The completed Respite Subsidy Program Application should be mailed to:
Nebraska Department of Health and Human Services
Medicaid & Long Term Care
State and Grant Funded Programs
PO Box 95026
Lincoln, NE 68509-5026

Questions: Call toll-free 1-800-358-8802 or in Lincoln call 471-9509