



DRAFT Division of Developmental Disabilities Application

Answer each question below that applies to you, as the applicant. Let us know if an alternative format is needed.

- 1. Do you have an intellectual or developmental disability? Yes No
 - 2. Did your intellectual or developmental disability occur before the age of 22? Yes No
 - 3. Are you currently receiving or have you ever received Aged & Disabled waiver services, Traumatic Brain Injury waiver services, or other Medicaid and Long Term Care services? Yes No We might be able to help you connect with other services.
- I agree to allow my information to be used and retrieved from data sources for this application. I have consent for all people I will list on the application for their information to be retrieved and used from data sources.***

Section 1 Applicant Name:
1. First: _____ Middle: _____ Last: _____ Ext. _____
2. List any previous names used, including maiden name, if applicable: _____
3. Birth date: _____ SSN: _____ Phone: () _____ Gender: _____
4. Address: _____ City: _____ State: _____ Zip: _____
5. Mailing Address: _____ City: _____ State: _____ Zip: _____
6. Email: _____

Section 2 Authorized Representative:
I am 19 or older and I authorize the following representative (e.g. parent, friend, advocacy organization) to provide assistance and consent for release of information.
Representative: _____
Relationship to applicant: _____ Phone: () _____
Address: _____ City: _____ Zip: _____

Section 3 Guardianship/Attorney in Fact
1. I am 19 or older and have a court-appointed guardian or Attorney in Fact (also known as a Power of Attorney or POA). Yes No NA
2. Name of Guardian or Attorney in Fact: _____ Phone: () _____
Address: _____ City: _____ State: _____ Zip: _____
If you have additional guardians, please list information requested above on a separate sheet and attach.

Section 4 Parent of a Minor

- 1. Applicant is a minor child under 19 years old. Yes No *If yes,*
- 2. Name of Parent/s: _____ Phone: () _____
- 3. Address: _____ City: _____ State: _____ Zip: _____

Section 5 Foster Care

- 1. Applicant is or has been a child in the legal custody of the Nebraska Department of Health and Human Services. Yes No *If in foster care now, name of CFS or CFOM worker:* _____ Phone: () _____
- 2. If applicable, name of NFC caseworker: _____ Phone: () _____

Section 6 Citizenship/Residency

- 1. I am a United States Citizen Yes No
 - 2. Place of birth: City: _____ State: _____ Country: _____
 - 3. I am a qualified alien under the Federal Immigration & Nationality Act Yes No
 - 4. Alien Number: _____ Immigration Status: _____
- I am a legal resident of Nebraska Yes No

Section 8 Additional Information

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.*

Section 9 Voter Registration

- 1. If you are not registered to vote where you live now, would you like to apply to register to vote? Yes No

Section 7 Records

Please submit the following records with this application, or provide names and contact information so that DDD may gather the information:

- 1. *Educational reports (i.e. Multi-Disciplinary Team (MDT) reports for the last ten years.*
- 2. School: _____ Address: _____
 City: _____ State: _____ Zip: _____ Phone: _____
- 3. *Related physician reports/diagnoses (i.e. medical, genetic syndrome/disorder) with current prescribed medications (include purpose of medication, dosage, and frequency of administration).*

Specific disability: _____

- 4. Medical Practitioner: _____ Address: _____
 City: _____ State: _____ Zip: _____ Phone: _____

5. *Reports from licensed psychologist for the last five years.*

- 6. Psychologist: _____ Address: _____
 City: _____ State: _____ Zip: _____ Phone: _____

7. *Reports from psychiatrist and therapist/counselor for the last five years.*

- 8. Psychiatrist: _____ Address: _____
 City: _____ State: _____ Zip: _____ Phone: _____

- 9. Therapist or Counselor: _____ Address: _____
 City: _____ State: _____ Zip: _____ Phone: _____

10. *Copy of court-appointed guardianship papers (if applicant is 19 years or older and has a court-appointed guardian).*

Please list additional school or medical contact information on a separate sheet and attach.

Authorization for Release of Information

I authorize the release of information requested by the DHHS. The requested information will be used solely in the administration of public assistance programs and will not be released to any other person or agency outside of the DHHS except that I understand the DHHS may release information to another agency when services of that agency have been requested or when the objective in obtaining the information is to provide services to me or to whom I am legally authorized to represent. This release of information is in effect while I am an applicant or recipient of public assistance or a financially responsible member and for any later investigations pertaining to my eligibility and receipt of benefits.

I'm signing this application under penalty of perjury, which means I've provided true answers to all of the questions to the best of my knowledge. I know that I may be subject to penalties under federal law if I intentionally provide false or untrue information.

Applicant, parent of a minor, court-appointed guardian, legal custodian, or Attorney in Fact Date

Authorized representative Date

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

Please submit the application and records to:

**Division of Developmental Disabilities
Nebraska Department of Health and Human Services
301 Centennial Mall South
PO Box 98947, Lincoln, NE 68509-8947
Or FAX # 402-471-8792 or e-mail to
DHHS.DDDCommunityBasedServices@nebraska.gov**