

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PO BOX 2992
OMAHA, NE 68103-2992

Case Number: - [REDACTED]
Case Name: - [REDACTED]
CONTACT - ACCESSNebraska
Telephone Number - (800) 383-4278
Fax Number: - (402) 595-1901
Notice Date: - [REDACTED]
Mail Date - [REDACTED]
Reprint Date - [REDACTED]

The name of the responsible adult and the mailing address is listed here.

[REDACTED]

Dates Notice was printed/mailed/reprinted

NOTICE OF ACTION

Supplemental Nutrition Assistance Program (SNAP) formerly known as the Food Stamp Program

Your application has been approved for [REDACTED]. The monthly benefit is \$ [REDACTED].

Individual

[REDACTED]

Status

Eligible
Eligible
Eligible
Eligible
Eligible
Eligible

Date eligibility begins.

Amount of SNAP benefits paid each month.

Name of each person eligible for and receiving benefits from SNAP

The benefit amount(s) listed above may be reduced if your household has a SNAP claim that has not been paid in full.

Your household is assigned to the Simplified Reporting category. You must report to DHHS if your household's income for the month goes above [REDACTED]. Income includes gross earned and unearned income before deductions, such as taxes.

If your household includes an Able Bodied Adult Without Dependents (ABAWD) who is working or volunteering, you must report if the ABAWD's work or volunteer hours drop below 20 hours per week averaged over a four-week period.

Both of these changes must be reported within 10 days after the end of the month in which the change occurs. These are the only changes that you must report.

If DHHS learns about a change from another source, DHHS is required to act on it and make changes to your case. If your income goes down or someone moves into your household, you may contact DHHS to see if you are eligible for additional benefits.

An Interim Report Form will be sent to you during the certification period listed on this notice. You are

See Reverse

required to complete and return this form or your benefits will end.

Your household is authorized to receive information and referral services through the Expanded Resource Program.

Your certification period is [redacted] to [redacted].

Beginning and ending dates of eligibility.

Aid to Dependent Children

Your application has been approved for [redacted]. The monthly benefit is \$ [redacted].

Individual

[redacted]

Status

Eligible
Eligible
Eligible
Eligible
Eligible

Amount of ADC benefits paid each

Name of each person eligible for and receiving benefits from ADC

Based on your eligibility for ADC, you may be eligible for participation in the Employment First Program. If you are eligible for the Employment First Program, supportive services will be available to assist you.

Medicaid

Date eligibility begins.

Approval

The following individual(s) are approved for medical coverage effective [redacted].

Individual

[redacted]

Status

Eligible
Eligible
Eligible
Eligible
Eligible

Medicaid Number

[redacted]

Name of each person eligible for and receiving benefits from Medicaid

If you have not previously received a permanent Medicaid ID card, you will receive a card within the next week. Please keep this card. You must show this card to all providers when getting medical/dental care. If you are required to participate in managed care, you will be contacted with more information.

Please remember if you receive assistance other than SNAP, you are required to report all changes in your situation within 10 days from the date of the change.

For information regarding the status of your case, call the Automated Voice Response System (VRU) at 1-800-383-4278.

Please visit www.ACCESSNebraska.ne.gov to complete applications for assistance, report changes and connect with other on-line services.