NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Department of Health and Human Services

Medicaid Work Requirements - Individual Declaration Form

First Name	Middle Initial	Last Name
Address		
Date of Birth	Last 4 digits of Social Security Number	

Individuals eligible for Nebraska Medicaid through Medicaid expansion are required to demonstrate compliance with Medicaid work requirements to qualify for Medicaid coverage. Medicaid expansion includes people who are aged 19-64, have a low income, and get their health insurance through Nebraska Medicaid. They cannot get Medicare and they are not pregnant or eligible on the basis of a disability. They also must be a U.S. citizen or meet Medicaid immigration rules. Low income means people who earn up to 138 percent of the federal poverty level which, for 2026, is about $22,025 per year for a single person or $45,540 for a family of four.

This form is intended to be used by such individuals to provide information which demonstrates compliance with Medicaid work requirements.

This form only accepts attestation for the activities listed below. There may be other activities not listed that require a different form of verification. For more information regarding Medicaid work requirements, please visit: dhhs.ne.gov/Pages/WorkRequirements.aspx

Qualifying Month(s):

- For **new applicants**, or individuals being added to a household, the questions on this form should be answered, and will be assessed based on the month before the month in which the individual applied (last month).
- For **existing members**, the questions on this form should be answered, and will be assessed, based on the time between now and your initial determination or last Medicaid renewal.

Please answer all questions completely and accurately to the best of your knowledge. If a question does not apply to you, answer "No" or enter "N/A." Questions marked with an asterisk (*) are required. Submitting an incomplete form may result in delays in processing your benefits or may result in the denial, termination or decrease in your benefits.

Who is this form being filled out for? *

- Name:_____
- Date of Birth:_____
- Last 4 of SSN:_____

Did this individual volunteer in their community in a qualifying month? Yes ☐ No ☐

- Number of volunteer hours per month:_____
- Name of Organization(s):_____
  - Address(es):_____
- Organization Contact(s):
  - Name(s):_____
  - Phone(s):_____

Did this individual participate in a work program in a qualifying month (including job training or employment services)? Yes ☐ No ☐

- Number of hours per month:_____
- Name of the Work Program(s):_____
  - Address(es):_____
- Work Program Contact(s):_____
  - Name(s):_____
  - Phone(s):_____

Was this individual enrolled in school or a career and technical education program in a qualifying month? Yes ☐ No ☐

If yes, please complete the following:

- Name of school or program: _____
- Number of credit hours enrolled: _____
- Enrollment begin date: _____
- Anticipated graduation date (if applicable): _____

Was this individual a parent, guardian, caretaker relative, or family caregiver of a child 13 years old or younger in a qualifying month? Yes ☐ No ☐
(Mark/answer all that apply):

- Does the child live in your household? Yes ☐ No ☐
- Is the child a relative? Yes ☐ No ☐
  - If no to the above questions, describe your relationship to the child who you provide care to:
  - If no to the above questions, how many hours of caregiving are provided?

Was this individual a parent, guardian, caretaker relative, or family caregiver of a disabled individual in a qualifying month? Yes ☐ No ☐

- Describe the chronic or other health condition, disability, or functional limitation of the individual to whom care is provided: _____
  _____

(Mark/answer all that apply):

- Does the disabled individual live in your household? Yes ☐ No ☐
- Is the disabled individual a relative? Yes ☐ No ☐
  - If no to the above questions, describe your relationship to the individual who you provide care to: _____
- How many hours of caregiving are provided? _____

Has the individual been incarcerated in the last 12 months? Yes ☐ No ☐

- Most Recent Release Date: _____
  - ☐ Check here if the individual is still incarcerated
- Name of Facility: _____
  - Address: _____

Was this individual considered medically frail or did they otherwise have special medical needs in a qualifying month? This includes anyone who is blind or disabled, has a substance use disorder, has a disabling mental disorder, has a physical, intellectual, or developmental disability that significantly impairs their ability to perform one or more activities of daily living (for example bathing, dressing, eating, or toileting), or who has a serious or complex medical condition. Yes ☐ No ☐

- Describe the health condition(s) the individual has that fit the list above : _____
  _____
  _____
  _____
- What doctor(s) or healthcare provider(s) does the individual see for these health conditions?
  - Name(s): _____
  - Address(es): _____
  - Telephone number(s): _____
- Were services provided related to the above health condition(s) while the individual was enrolled with Nebraska Medicaid? Yes ☐ No ☐

Was this individual participating in a drug addiction or alcohol treatment and rehabilitation program in a qualifying month? (If so, answer the following based on the most recent participation.) Yes ☐ No ☐

- Name of Facility: _____
  - Facility Address: _____
  - Contact Name: _____

■ Phone: _____
• Date(s) of Service: _____
• Were these services provided while the individual was enrolled with Nebraska Medicaid? Yes ☐ No ☐
Is this individual a veteran with a VA disability rating of 100% (total)? Yes ☐ No ☐
• If yes, effective date of disability rating: _____
Did this individual receive inpatient hospital services, nursing facility services, services in an intermediate care facility for individuals with intellectual disabilities (ICF/DD), inpatient psychiatric hospital services, or other similar services in a qualifying month? Yes ☐ No ☐
• Date(s) of Service: _____
• Name of Facility: _____
• Were these services provided while the individual was enrolled with Nebraska Medicaid? Yes ☐ No ☐
Did this individual (or their dependent) travel outside of their community for an extended period of time to receive medical care for a serious medical condition during a qualifying month? Yes ☐ No ☐
• Date(s) of Service: _____
• Name of Facility(s): _____
■ Address(es): _____
• Name of individual(s) receiving medical care: _____
• Describe the health condition(s) being treated: _____ _____
• Reason for travel outside the individual's community: _____ _____
• Were these services provided while the individual was enrolled with Nebraska Medicaid? Yes ☐ No ☐

I hereby authorize the Nebraska Department of Health and Human Services and its agents to request from third parties any information or documents necessary for the administration of its programs. Such third parties shall include but not be limited to: the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, a consumer reporting agency, and financial institutions. Any third party shall also be authorized to provide any information or documents requested by the Nebraska Department of Health and Human Services concerning myself or, when required by law, any other person. I further authorize the Nebraska Department of Health and Human Services to release such information or documents to cooperating State or Federal Agencies in accordance with any applicable law.

This authorization is given only to the Nebraska Department of Health and Human Services to be used in the administration of its programs and for no other purposes. It shall continue in effect until the earliest of the rendering of a final adverse decision on my application for medical assistance, the cessation of my eligibility for medical assistance, or such time as I state in writing that I rescind this authorization.

I release any third party from any and all liability to me and, when applicable, any other person, for supplying the aforementioned information or documents.

I'm signing this form 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.

A REPRODUCTION OF THIS RELEASE IS AS VALID AS THE ORIGINAL

_____ Applicant/Beneficiary Signature	Date:
_____ Signature and Relationship of Person Who Helped	Date:

I hereby authorize the Nebraska Department of Health and Human Services and its agents to request from third parties any information or documents necessary for the administration of its programs, including financial information. I also authorize the release of my Social Security Number for this purpose.

Additional comments:

If you would like to fill out this form electronically, scan this QR code or go online to iServe.Nebraska.gov for more information

English
The Nebraska Department of Health and Human Services provides language assistance services and auxiliary aids and services, free of charge. For language assistance services or auxiliary aids, please call (402) 471-3121 or speak to someone at the front desk.

Spanish
El Departamento de Salud y Servicios Humanos de Nebraska proporciona servicios de asistencia lingüística y ayudas y servicios auxiliares, de forma gratuita. Para servicios de asistencia lingüística o ayudas auxiliares, por favor llame al (402) 471-3121 o hable con alguien en la recepción.

Vietnamese
Sở Y tế và Dịch vụ Nhân sinh Nebraska cung cấp dịch vụ hỗ trợ ngôn ngữ và các thiết bị hỗ trợ bổ trợ, hoàn toàn miễn phí. Để được hỗ trợ ngôn ngữ hoặc sử dụng các thiết bị hỗ trợ bổ trợ, vui lòng gọi số (402) 471-3121 hoặc trao đổi với nhân viên tại quầy lễ tân.

Arabic
تقدّم دائرة الصحة والخدمات الإنسانية في نبراسكا خدمات المساعدة اللغوية والوسائل المساعدة والخدمات الإضافية مجانًا. للحصول على خدمات المساعدة اللغوية أو الوسائل المساعدة، يُرجى الاتصال على الرقم (402) 471-3121 أو التحدث إلى أحد الموظفين في مكتب الاستقبال.

French
Le Département de la Santé et des Services Sociaux du Nebraska propose gratuitement des services d'assistance linguistique et des aides et services auxiliaires. Pour obtenir ces services, veuillez appeler le (402) 471-3121 ou vous adresser à l'accueil.

Chinese
內布拉斯加州衛生和公共服務部免費提供語言援助服務和輔助工具和服務。如需語言輔助服務或輔助工具，請致電（402） 471-3121 或與前臺人員聯系。

German
Das Gesundheits- und Sozialministerium von Nebraska bietet kostenlose Sprachunterstützung sowie Hilfsmittel und Dienstleistungen an. Für Sprachunterstützung oder Hilfestellungen wenden Sie sich bitte an die Telefonnummer (402) 471-3121 oder sprechen Sie mit einem Mitarbeiter an der Rezeption.

Somali
Waaxda Caafimaadka iyo Adeegyada Aadanaha ee Nebraska waxay bixiyaan adeegyada kaalmada luqadda iyo qalabka caawiyo dadka wax maqalka ku adeegyahay oo bilaash ah. Adeegyada kaalmada luqadda ama qalabka caawiyo dadka wax maqalka ku adeegyahay, fadlan wac (402) 471-3121ama la hadal qofka jooga soo dhaweynta.

Swahili
Idara ya Afya na Huduma za Kibinadamu ya Nebraska hutoa huduma za usaidizi wa lugha na usaidizi wa ziada na huduma, bila malipo. Kwa huduma za usaidizi wa lugha au usaidizi wa ziada, tafadhali piga simu (402) 471-3121 au zungumza na mtu aliye kwenye dawati la mapokezi.

Nepali
नेब्रास्का स्वास्थ्य तथा मानव सेवा विभागले भाषा सहायता सेवाहरू र सहायक सहायता र सेवाहरू नि:शुल्क प्रदान गर्दछ। भाषा सहायता सेवाहरू वा सहायक सहायताहरूको लागि, कृपया (402) 471-3121 मा कल गर्नुहोस् वा फ्रन्ट डेस्कमा कसैसँग कुरा गर्नुहोस्।

Tagalog
Nagbibigay ang Nebraska Department of Health and Human Services ng mga serbisyong pantulong sa wika at mga karagdagang tulong at serbisyo, nang walang bayad. Para sa mga serbisyong pantulong sa wika o mga karagdagang tulong, mangyaring tumawag sa (402) 471-3121 o makipag-usap kaninuman sa front desk.

Russian
Департамент здравоохранения и социальных служб штата Небраска предоставляет бесплатные услуги языковой поддержки, а также вспомогательные средства и услуги. Для получения услуг языковой поддержки или вспомогательных средств позвоните по телефону (402) 471-3121 или обратитесь к кому-нибудь на стойке регистрации.

Ukranian
Департамент охорони здоров'я та соціальних служб штату Небраска надає безкоштовні послуги мовної підтримки, а також допоміжні засоби та послуги. Для отримання послуг мовної підтримки або допоміжних засобів зателефонуйте (402) 471-3121 або зверніться до когось на стійці реєстрації.

Telugu
నెబ్రాస్కా డిపార్ట్‌మెంట్ ఆఫ్ హెల్త్ అండ్ హ్యూమన్ సర్వీసెస్ భాషా సహాయ సేవలు మరియు సహాయక సహాయాలు మరియు సేవలను ఉచితంగా అందిస్తుంది. భాషా సహాయ సేవలు లేదా సహాయక సహాయాల కోసం, దయచేసి (402) 471-3121 కు కాల్ చేయండి లేదా ముందు డెస్క్ వద్ద ఉన్న ఎవరితోనైనా మాట్లాడండి.

Hindi
द नेब्रास्का डिपार्टमेंट ऑफ हेल्थ एंड ह्यूमन सर्विसेज़ मुफ़्त भाषा सहायता सेवाएं तथा सहायक साधन एवं सेवाएं प्रदान करता है। भाषा सहायता सेवाओं या सहायक साधनों के लिए, कृपया (402) 471-3121 पर कॉल करें या फ्रंट डेस्क पर किसी से बात करें।