Nebraska Department of Health & Human Services
Division of Public Health | Health Promotion

Chronic Renal Disease Program Application

NEBRASKA
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DEPT. OF HEALTH AND HUMAN SERVICES

Please print legibly!

When complete, give to your dialysis social worker.

Client Information

Name: _____
(Last) (First) (MI)

Street Address: _____

City: _____ State: _____ Zip: _____

*SSN: _____ Birthdate: _____ Phone: _____

Marital Status: _____ **Race: _____
Married | Single | Divorced Separated | Widowed
African American | Asian | Caucasian/White | Hispanic | Native American | Other

Gender: Female Male Other *(Circle One)*

Veteran Status: Yes No *(Circle One)*

Employment Status: Disabled Employed Retired Unemployed *(Circle One)*

If client is under the age of 19, indicate the parent/guardian:

Parent/Guardian Name: _____
(Last) First)

**It is mandatory to provide your Social Security Number (SSN). It will be used to determine eligibility and for administrative purposes. The information is confidential and will only be released as required by law. **For statistical purposes only.*

Dialysis Center | Social Worker

Dialysis Center: _____

Dialysis Center Address: _____

City: _____ State: _____ Zip: _____

Social Worker (SW): _____

Client Name: _____

Income

Submit a copy of the <u>most recent</u> FEDERAL Income Tax Return showing the Adjusted Gross Income OR a copy of the <u>most recent</u> Social Security Administration (SSA) benefit statement.

If applicable, include any retirement or pension benefit statement(s) as well.

<u>Important</u>:

- **If married, your spouse's income source(s) must also be submitted.**
- **If you are claimed as a dependent on someone else's Income Tax Return, their income sources must also be provided.**

Total of last year's income: _____

If future income will change significantly, include a one-page statement why on page 4 and provide documentation.

☐ Check if you did not file an Income Tax Return. Briefly explain why: _____

_____

_____

Are you claimed as a dependent on someone else's Income Tax Return? ☐ Yes ☐ No

If yes, whose? _____

Do you have relatives legally responsible to provide care and treatment for you who refuse to provide such care and treatment?

☐ Yes ☐ No

If yes, note whom and relationship: _____

Within the past two years, have you given away – or sold for less than fair market value – any property?

☐ Yes ☐ No

If yes, note the type of property, the value of the property and why: _____

_____

Household

Family members living in the home during the past year:

Name	Age	Relationship	Employed
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Client Name: _____

Health Insurance

Do you have *private health insurance*? □ Yes □ No

If yes, provide the following information:

Insurance Company Name	***Type of Coverage***	***Effective Date***	***Policy Number***

Do you have *Medicare*? □ Yes □ No □ No, but have applied
If yes, provide the following information:

Type of Coverage (mark each box that applies)	***Effective Date***	***Medicare ID Number***
■ Part A □ Part B □ Part C □ Part D		

Do you have *Medicaid*? □ Yes □ Yes (Share of Cost) □ No □ No, but have applied

If yes, provide the following information:

Medicaid ID Number

Name: _____

Use this page to indicate if future income will change significantly (due to death of a family member, disability status, inability to work, etc.) or if other areas of the application require greater explanation. Do **not** exceed one-page. ***Documentation is required to substantiate income explanations.*** For example, a letter from a past employer, a letter from your doctor stating your inability to work as a result of your illness, etc.

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: _____

Client Name: _____

Release of Information

The following people have permission to contact the Nebraska Chronic Renal Disease Program and discuss your renal-related condition and/or application and renewal requirements:

Name	Year of Birth	Relationship to You

The consent to release information may be revoked by you at any time by informing the Renal Program in writing. If left blank, your case will not be discussed with anyone but your renal social worker, your service providers or you. Renal social workers and service providers may access an electronic system to verify your Renal Program eligibility.

Initial your understanding: _____

Date: _____

Affirmation

I, the undersigned, hereby authorize the release of information requested from me to the Nebraska Department of Health and Human Services.

The information will be used to determine my eligibility for assistance from the Nebraska Chronic Renal Disease Program.

Further, if approved, it is understood that the Program only assists with the cost of pharmaceuticals and dialysis, and **does not pay** the expenses of any other illness. In accordance with 181 NAC 1, **payment for services will be provided as long as current state appropriations are available and I continue to meet the Program eligibility requirements**.

I affirm that the information provided in this application is true, complete and accurate.

_____

Client Signature

_____

If client is under 19 years of age, Parent or Guardian signature is required.

Date: _____

Client Name: _____

Medical Certification

Diagnosis: _____

_____

_____

_____

Recommended Therapy: _____

_____

_____

_____

Date of First Dialysis Treatment: _____

Transplant Date: _____

By signing, the medical certifier confirms that the client meets the criteria for chronic renal disease.

Signature: _____

Printed Name: _____ Degree: _____

Address: _____

City, State, Zip: _____

Telephone: _____

Date: _____

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Notice of Nondiscrimination and Program Accessibility

This notice is provided as required by Title II of the Americans with Disabilities Act of 1990 (ADA) and Section 504 of the Rehabilitation Act of 1973 (Sec. 504), and Section 1557 of the Affordable Care Act (ACA/Sec. 1557).

The Nebraska Department of Health and Human Services (DHHS) is committed to providing equal access to employment, programs, service, activities and benefits to qualified individuals with disabilities. DHHS complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, sex, or disability in admission to its programs, services, or activities; in access to them; in treatment of individuals with disabilities; in provision of benefits, in its hiring or employment practices, or in any aspect of their operations.

DHHS will generally, upon request, provide appropriate aids and services leading to effective communication for qualified individuals with disabilities so that they can participate equally in DHHS's programs, services and activities. This includes qualified sign language interpreters, written information in other formats (large print, audio, accessible electronic formats, and other formats). Free language services are available to people whose primary language is not English, such as qualified interpreters and information written in other languages. Any individual who requires an auxiliary aid or service for effective communication related to any DHHS program, service or activity should contact the ADA, Sec. 504, and ACA/Sec. 1557 Compliance Coordinator.

DHHS will make reasonable modifications to policies and programs to ensure that individuals with disabilities have an equal opportunity to enjoy all of its programs, services, activities, and benefits. Any individual who requires a modification to a policy or program should contact the ADA, Sec. 504, and ACA/Sec. 1557 Compliance Coordinator.

Any complaint that a DHHS program, service or activity is not accessible to individuals with disabilities, or has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, should be directed to the ADA, Sec. 504, and ACA/Sec. 1557 Compliance Coordinator. You can file an ACA/Section 1557 complaint in person or by mail, fax, or email. If you need help filing a complaint the ADA, Sec. 504, and ACA/Sec. 1557 Coordinator is available to help you.

The ADA and ACA do not require DHHS to take any action that would fundamentally alter the nature of its programs or services, or impose any undue financial or administrative burden upon DHHS. Questions, complaints or requests for additional information regarding the ADA, Section 504, and ACA/Sec. 1557 may be forwarded to the designated ADA, Section 504, and ACA/Section 1557 Compliance Coordinator:

Robin Hadfield, ADA, Sec. 504, and ACA/Sec. 1557 Compliance Coordinator
Nebraska Department of Health and Human Services
301 Centennial Mall South
Lincoln, NE 68509
Phone: (402) 471-7241

You can also file a complaint with the U.S. Department of Health and Human Services, Office of Civil Rights, electronically through the Office of Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

This notice is available in large print or in audio by contacting the ADA, Sec. 504, and ACA/Sec. 1557 Coordinator.

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Limited English Proficiency Statement

English

ATTENTION: If you speak English, language assistance services, free of charge, are avalialbe to you.

Call 1-800-722-1715 (TTY: 402-471-9570 or 711 or 1-800-833-7352).

Spanish

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.

Llame al 1-800-722-1715 (TTY: 402-471-9570 or 711 or 1-800-833-7352).

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn.

Gọi số 1-800-722-1715 (TTY: 402-471-9570 or 711 or 1-800-833-7352).

Chinese

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-722-1715

(TTY: 402-471-9570 or 711 or 1-800-833-7352).。

Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-722-1715 (رقم هاتف الصم والبكم:-(TTY: 402-471-9570 or 711 or 1-800-833-7352).

Karen

ဟ်သူဉ်ဟ်သး– နမ့်ကတိၤ ကညီ ကျိာ်အဃိ, နမၤနှ် ကျိာ်အတ်မၤစၢၤလ၊ တလၫ်ဘူဉ်လၫ်စ့ၤ နီတဖံးဘဉ်သ့နှဉ်လီၤ. ကိး

1-800-722-1715; (TTY: 402-471-9570 or 711 or 1-800-833-7352).

French

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement.

Appelez le 1-800-722-1715 (ATS : 402-471-9570 or 711 or 1-800-833-7352).

Cushite

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama.
Bilbilaa 1-800-722-1715; (TTY: 402-471-9570 or 711 or 1-800-833-7352).

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur

Verfügung. Rufnummer: 1-800-722-1715 (TTY: 402-471-9570 or 711 or 1-800-833-7352).

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-722-1715 (TTY:

402-471-9570 or 711 or 1-800-833-7352). 번으로 전화해 주십시오.

Nepali

ध्यान दिनुहोस्: तपाईले नेपाली बोल्नुहुन्छ भने तपाईको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-800-722-1715

(टिटिवाइ: 402-471-9570 or 711 or 1-800-833-7352). ।

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.

Звоните 1-800-722-1715 (телетайп: (TTY: 402-471-9570 or 711 or 1-800-833-7352).

Laotian

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ ທ່ານ. ໂທຣ 1-800-722-1715 (TTY: 402-471-9570 or 711 or 1-800-833-7352).

Kurdish

ئاگاداری: ئەگەر بە زمانی کوردی قسە دەکەیت، خزمەتگوزاریەکانی یارمەتی زمان، بەخۆڕایی، بۆ تۆ بەردەستە. پەیوەندی بە (TTY: 402-471-9570 or 711 or 1-800-833-7352) (1-800-722-1715) بکە.

Persian (Farsi)

توجه: اگر به زبان فارسی گفتگو می شود، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-722-1715 (TTY: 402-471-9570 or 711 or 1-800-833-7352) تماس بگیرید.

Japanese

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-722-1715（TTY:

402-471-9570 or 711 or 1-800-833-7352）まで、お電話にてご連絡ください。