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

Medicaid and Long-Term Care

Supplemental Application for Medicaid and Insurance Affordability Programs

This form is utilized in conjunction with the application for Medicaid and Insurance Affordability Programs (Financial Assistance).

This form is required for:

- **Those over age 65**
- **Those under age 65, who are disabled and/or applying for a disability determination, and**
- **Those requesting a determination based upon a medical need**
- **Aged Blind, or Disabled (AABD) applying for a supplemental grant payment**

Complete the form and submit it to a local Department of Health and Human Services office.

This form can be mailed to:
DHHS, Medicaid Eligibility Program
PO Box 2992
Omaha, NE 68103-2992

Contact Medicaid at 855-632-7633 or (402) 473-7000 Lincoln or (402) 595-1178 Omaha if assistance is needed in completing this form.

Email Address:

☐ **Email:** By checking 'this box', I elect to receive notification of my written notices and other correspondence regarding my benefits from DHHS through the email address above. These benefits include; Medicaid, CHIP, SNAP, ADC, LIHEAP, CC Subsidy, AABD payment and SSAD. I will no longer receive information through the mail. I understand I will receive an email notification of the correspondence, which will provide a link to the DHHS ACCESSNebraska website where I can access the correspondence. I understand that I must create an authenticated account on the ACCESSNebraska website in order to view my correspondence in Benefit Inquiry.

☐ **Text Messaging:** By checking 'this box', I agree to receive text messages on the cell phone number above from DHHS regarding my benefits. These benefits include; Medicaid, CHIP, SNAP, ADC, LIHEAP, CC Subsidy, AABD payment and SSAD. I agree to contact DHHS if my cell phone number changes or if this number is no longer in my possession. I understand that I can opt out of this in the future by contacting DHHS. *NOTE: Text messaging is currently under development and is targeted to be available in the near future.*

1. **Please complete the table below for each person in your household:**
   For Living Arrangement please use the following: Live in a House—rent, own, mortgage; Rent apartment, duplex, triplex; Rent a room; Board and Room; Adult Family Home; Center for Developmentally Disabled; Assisted Living; Nursing Home/Long Term Care Facility; Homeless Shelter; Drug Abuse or Alcohol Treatment Center; or for Other list type.

Name:	Birthdate:	Social Security Number:	Marital Status & Effective Date (M,S,D):	Living Arrangement:

2. **Is anyone requesting Aged and Disabled Waiver, Personal Assistance Services, PACE, or State Supplemental grant payment?**
   Aged and Disabled Waiver, Personal Assistance Programs and PACE provide care to the individual to help maintain daily living; some examples of services provided include: assistance with bathing, dressing, meal preparation, house cleaning, shopping for food, transportation, etc. PACE is only available in certain geographical areas.

   ☐ **Yes** ☐ **No** **Who:** _____

3. **If you live in a facility or location other than home, or apartment please provide:**

   Name of person residing in facility: _____
   Facility Name: _____
   Facility Address: _____City _____ State _____ Zip: _____
   Phone Number: _____
   Date admitted/moved into facility: _____

4. **If you were admitted to or moved into the facility within the last six months and still are paying housing expenses from previous residence, please list the expenses:**

Expense:	Amount:	Paid to:	Frequency:
Rent:	$		
Mortgage:	$		
Lot Rent:	$		
Property Taxes:	$		
Home Owners Insurance:	$		
Condominium/Association Fees:	$		
Electric Company:	$		
Natural Gas Company:	$		

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

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5. Complete if anyone has a Guardian, Conservator, Power of Attorney?

Name:	Guardian, Conservator, Power of Attorney:	Name and Address of Guardian, Conservator, Power of Attorney:

6. Complete this section for those in household with Disability. If anyone in the household under age 65 has a disability, please answer the following questions. If no one is disabled proceed to question 7.

Name:
Has disability been determined? ☐ Yes ☐ No If yes, what is the date of disability started:
Determined by Social Security? ☐ Yes ☐ No If yes, what is the date of disability started:
Is this condition the result of an accident? ☐ Yes ☐ No If yes, person's name and date of accident:
Is an attorney involved? ☐ Yes ☐ No If yes, name of attorney and phone number:
Is an insurance company involved? ☐ Yes ☐ No If yes, name of company and phone number:

7. Does anyone in your household have ongoing medical costs? ☐ Yes ☐ No If yes, who?

8. Do you or anyone in your household have any of the following resources? This includes resources owned in your name or in the name of any household member.

Type of Resource:	Yes or No:	Amount:	Owned by:	Account Number:	Institution Name:
Cash:	☐ ☐		1. 2.		
Checking:	☐ ☐		1. 2.		
Savings:	☐ ☐		1. 2.		
Real Estate/Real Property/ Farmland:	☐ ☐		1. 2.		
Trusts:	☐ ☐		1. 2.		
Life Insurance:	☐ ☐		1. 2.		
Burial fund/trust/spaces:	☐ ☐		1. 2.		
Nursing Home Account:	☐ ☐		1. 2.		
401K, IRA, Keogh, Annuities:	☐ ☐		1. 2.		
Certificate of Deposits:	☐ ☐		1. 2.		
Savings Bond:	☐ ☐		1. 2.		
Stocks/Investments:	☐ ☐		1. 2.		
Crop/Livestock/Machinery:	☐ ☐		1. 2.		

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

Medicaid and Long-Term Care

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9. Does your name or any household member's name appear on the title of any licensed or unlicensed vehicles (include cars, trucks, motorcycles, ATVs, boats, RVs, snowmobiles, trailers, aircraft, etc.) Please complete for each vehicle:

Owner:	Type of Vehicle:	Model:	Year:	Value:	Amount Owed:
					$
					$
					$
					$

10. Have you or your spouse sold, traded or given away anything of substantial value within the past 60 months (five years)? Please complete for each item:

Owner:	What was sold, traded or given away:	When:	Value:
			$
			$

11. Does anyone in the household receive money for Child Support/Alimony? ☐ **Yes** ☐ **No**

If yes, who receives the child support/alimony? _____

Amount received?_____

How often? _____

12. Are you or anyone in your household billed for Child Care or Dependent Care? ☐ **Yes** ☐ **No**

If yes, who provides the care? _____

Amount billed? _____

How often billed? _____

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DEPT. OF HEALTH AND HUMAN SERVICES

YOU HAVE THE RIGHT TO:

- Apply and discuss any action taken on your application or case with a worker or a worker's supervisor.
- Be assisted in the application process by the person of your choice.
- Referral to other private or public agencies.
- See a copy of the program regulations.
- Have an interview in your home, at a mutually agreed upon location, or by telephone.
- Reasonably prompt action on your application for benefits.
- Adequate notice of any action affecting your application or case.
- Have program requirements and benefits fully explained.
- Have your information treated confidentially.

YOU HAVE THE RESPONSIBILITY TO:

- Provide complete and accurate information. You may be subject to criminal penalties under applicable state or federal laws if you do not provide complete and accurate information. You are primarily responsible for providing proof of your household situation, but a worker will assist you in obtaining verification if you cooperate with the application process.
- Apply for and accept any potential benefits or income you may be eligible for if requested to do so by a worker.
- Pay a co-pay for certain medical services if required to do so.
- Cooperate with state and federal personnel in a Quality Control review.
- Cooperate with Nebraska Managed Care Program for certain Medicaid recipients.
- Ask questions if you do not understand something about any program requirements.

FAIR HEARINGS

If you disagree with any action taken by Nebraska Department of Health and Human Services (DHHS) that affects your benefits, you may request a fair hearing in writing. A fair hearing request must be made within 90 days of the action or inaction. You or your representative have the right to examine your case record. At the hearing you may represent yourself or be represented by another person.

CIVIL RIGHTS

In accordance with Federal law and U.S. Department of Health and Human Services (HHS) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability.

To file a complaint of discrimination, contact: HHS Director, Office for Civil Rights, Room 506-F, 200 Independence Avenue, S.W., Washington, D.C., 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TTY). HHS are equal opportunity providers and employers.

REPORTING CHANGES FOR MEDICAID

Report all changes within 10 days to DHHS such as:

- Changes in the household (someone moves in or out)
- If you move
- New employment
- Termination or change of employment - including job training or other work activities
- Change in the amount of monthly income
- Changes in disability or incapacity
- A change in health insurance
- A change in a resource

You may report these changes online: ACCESSNebraska.ne.gov - click on 'Report Changes'.

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DEPT. OF HEALTH AND HUMAN SERVICES

MEDICAID

Third Party Liability: Individuals who receive Medical Assistance (Medicaid) assign to the Department of Health and Human Services (DHHS) their right to any medical support or other payment for medical care, agree to cooperate with DHHS in establishing paternity, and cooperate with DHHS in obtaining any available third party such as an insurance payment or court settlement. Medicare benefits are not assigned. Individuals must cooperate with DHHS in obtaining reimbursement for the cost of medical care and services for any members of the assistance unit. Refusal to cooperate will result in the termination of medical assistance eligibility for that individual. DHHS will waive the requirement to cooperate if it determines that the individual has good cause for refusing to cooperate. If at any time you want to claim good cause, you must tell your worker that you think you have good cause. Good cause is a finding by the DHHS that cooperation is against the best interests of the child or against the best interests of the individual because it is anticipated that cooperation will result in reprisal against, and cause physical or emotional harm, to the individual or other person. **NEBRASKA REVISED STATUTES §§ 68-716, 68-916, and 68-917**.

Medical Records Release: Upon request, any person who has medical records and information or the custody of such records regarding Medicaid recipients must release them to the DHHS. This information will be used as provided in the Notice of Information Privacy Practices.

Medical Reimbursement Agreement: When DHHS pays for services for a Medicaid recipient, the amount DHHS has paid to treat the injury or illness must be included in any legal claim made against a third party. If the Medicaid recipient later receives an insurance or court settlement, DHHS must be notified of the settlement and repaid from the settlement for the medical assistance DHHS has previously paid.

Medicaid:

- Present proof of your current Medicaid eligibility to medical providers before obtaining services.
- Ask your medical provider or worker about which services are covered.
- Inform your worker and your medical providers of any health insurance coverage you have (including dental coverage).
- Agree to enroll in employer-based group health insurance if DHHS determines it is cost effective.
- Agree to comply with managed care requirements.
- Pay the cost of all non-covered medical expenses.
- If you get any bills or statements from providers or collection agencies, you are responsible to tell them right away your coverage is Nebraska Medicaid.

Failure to follow certain conditions may result in your being responsible to pay the bills.

Annuity Requirement As a condition of receiving medical assistance coverage for long-term care services for you or your spouse, DHHS must become the remainder beneficiary of any annuity under standards prescribed by the U.S. Secretary of Health and Human Services.

Medicaid Estate Recovery Program: Under Federal law (Social Security Act, Title 19, Sec. 1917 [42 U.S.C. 1396P]) and State law (Nebraska Rev.Stat. 68-919), the Medicaid Estate Recovery Program authorizes DHHS to make recovery from the estates of deceased Medicaid clients who were permanently institutionalized or were over the age of 55 when benefits were provided. The Federal and State laws provide for certain exemptions to the Medical Assistance Estate Recovery Program (471 NAC 38-000). For further information or questions about the Medicaid Estate Recovery Programs, you should contact DHHS and request the "Medicaid Estate Recovery" program brochure.

NEBRASKA
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DEPT. OF HEALTH AND HUMAN SERVICES

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When this application is signed I agree that

For purpose of complying with Neb. Rev. Stat 4-0108 through 4-114, 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. This information may be verified by USCIS (formerly known as INS) through the submission of information from the application to USCIS, and that the submitted information received from USCIS may affect the household's eligibility and level of benefits. I understand my responsibilities and agree to fulfill them. I understand I may have to provide proof of what I have said. If written proof is not available, I agree to give the name or organization so that the Department of Health and Human Services may obtain the necessary proof. I will cooperate fully with state and federal personnel in a Quality Control Review.

I authorize the release of the Social Security Numbers provided on this application to Department of Health and Human Services to use for the purposes mentioned in the Rights and Responsibilities.

Authorization for Release of Information

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.

A reproduction of this release is as valid as the original.

_____ _____
Signature of Applicant Date — Date

_____
Printed Name (if Applicant signs with a mark)

_____ _____
Signature of Witness (if a mark was used) — Date

_____ _____
Signature of Other Adult Household Member — Date

_____ _____
Signature of Person Who Helped - Authorized Representative/ Guardian/Conservator/Power of Attorney — Date

COMPLETE THE FOLLOWING IF GUARDIAN/CONSERVATOR/ POWER OF ATTORNEY

_____
Name of Guardian/Conservator/Power of Attorney

_____
Address and Phone Number of Guardian/Conservator/ Power of Attorney

Does Guardian/Conservator receive payment for services?

☐ 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 its programs, including financial information. I also authorize the release of my Social Security Number for this purpose.

_____ _____
Signature of Spouse of Applicant — Date:

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DEPT. OF HEALTH AND HUMAN SERVICES

Notice of Information Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you may access this information. Please review it carefully. *Effective:04/14/2003*

The Department of Health and Human Services of the State of Nebraska, and those Agencies inclusive of health care facilities and medical assistance programs that are affiliated under the common control of the Nebraska Partnership for Health and Human Services Act, are required by federal law to maintain the privacy of Protected Health Information and to provide notice of its legal duties and privacy practices with respect to Protected Health Information.

PRACTICES AND USES:

DHHS may access, use and share medical information for purposes of :

- **Treatment:** We may use your medical information to provide you with medical treatment or services. For Example; a doctor may need to tell the dietitian if you have diabetes so that appropriate meals can be prepared.
- **Payment:** We may use and disclose your medical information so that the treatment and services you receive can be billed. For example, we may use your medical information from a surgery you received at the hospital so that the hospital can be reimbursed.
- **Operations:** We may use and disclose medical information about you for medical operations. For example, we may use medical information to review your treatment and services and to evaluate the performance of the staff.

OTHER PERMITTED USES AND DISCLOSURES THAT MAY BE MADE WITHOUT CONSENT:

- **Required By Law:** We may use or disclose your Protected Health Information to the extent that the use or disclosure is required by law. You will be notified, if required by law, of any such uses or disclosures.
- **Public Health:** We may disclose your Protected Health Information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information.
- **Communicable Diseases:** We may disclose your Protected Health Information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.
- **Health Oversight:** We may disclose Protected Health Information to a health oversight agency for activities authorized by law, or other activities necessary for appropriate oversight of the health care system, government benefit programs, other government regulatory programs, and civil rights laws.
- **Abuse or Neglect:** We may disclose your Protected Health Information to a public health authority that is authorized by law to receive reports of abuse or neglect. The disclosure will be made consistent with the requirements of applicable federal and state laws.
- **Legal Proceedings:** We may disclose Protected Health Information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), and in certain conditions in response to a subpoena, discovery request, or other lawful process.
- **Law Enforcement:** We may also disclose Protected Health Information, so long as applicable legal requirements are met, for law enforcement purposes.
- **Food and Drug Administration:** We may disclose your Protected Health Information to a person or company as required by the Food and Drug Administration.
- **Coroners, Funeral Directors, and Organ Donation:** We may disclose Protected Health Information to a coroner or medical examiner for identification purposes, cause of death determinations, or for the coroner or medical examiner to perform other duties authorized by law.
- **Research:** We may disclose your Protected Health Information to researchers when their research has been approved by an institutional review board to ensure the privacy of your Protected Health Information.
- **Criminal Activity:** Consistent with applicable federal and state laws, we may disclose your Protected Health Information if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
- **Military Activity and National Security:** When the appropriate conditions apply, we may use or disclose Protected Health Information of individuals who are Armed Forces personnel.
- **Workers' Compensation:** We may disclose your Protected Health Information as authorized to comply with workers' compensation laws and other similar legally established programs.
- **Inmates:** We may use or disclose your Protected Health Information if you are an inmate of a correctional facility in the course of providing care to you.
- **Required Uses and Disclosures:** Under the law, we must make disclosures when required by the Secretary of the U.S. Department of Health and Human Services to investigate or determine our compliance with the requirements of 45 CFR, Title II, Section 164, et. seq.

OTHER USES OF MEDICAL INFORMATION

You can provide us written authorization to use your medical information for other purposes; you may revoke that permission, in writing, at any time.

THIS NOTICE IS AVAILABLE IN LARGER PRINT AND WITH DETAILED EXPLANATION UPON REQUEST.

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DHHS, HIPAA Privacy and Security Office, 301 Centennial Mall South, 3rd Floor, P.O. Box 95026, Lincoln, NE 68509-5026

YOUR RIGHTS TO PRIVACY:

❖ **Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records but does not include psychotherapy notes. To inspect and copy your medical information, you must submit your request in writing at the Site of Service, or to the State of Nebraska, Department of Health and Human Services, HIPAA Privacy and Security Office at the address on the top of this Notice. If you request a copy of information, we may charge a fee for the cost of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request the denial be reviewed. For more information call **(402) 471-8417.**

❖ **Right to Amend.** If you feel that medical information about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by or for DHHS. To request an Amendment, your request must be made in writing and submitted at the Site of Service, or to the State of Nebraska, Department of Health and Human Services, HIPAA Privacy and Security Office**.** In addition you must provide a reason which supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for DHHS;
- Is not part of the information which you would be permitted to inspect and copy; or,
- Is accurate and complete.

❖ **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list, you must submit your request in writing at the Site of Service, or to the State of Nebraska, Department of Health and Human Services, HIPAA Privacy and Security Office address on the top of this Notice. Your request must state a time period for the disclosures, which may not be longer than six (6) years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list to be provided to you: for example, on paper, or by e-mail.

❖ **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you can ask that we not use or disclose information about a surgery you had performed.

❖ **We are not required to agree to your request for restrictions.** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing at the Site of Service, or to the State of Nebraska, Department of Health and Human Services, HIPAA Privacy and Security Office at the address on the top of this Notice. In your request you must tell us: (1) what information you want to limit, (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply; for example, disclosures to your spouse.

❖ **Right to Request Confidential Communications**. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing at the Site of Service, or to the State of Nebraska, Department of Health and Human Services, HIPAA Privacy and Security Office. Your request must specify how or where you wish to be contacted.

How to file a complaint about your privacy rights

If you believe your privacy rights have been violated, you may file a complaint with **DHHS** or with the **Secretary of the U.S. Department of Health and Human Services**. To file a complaint with DHHS, you may contact our Privacy Contact, **DHHS HIPAA Privacy and Security Office** at **(402) 471-8417** Monday through Friday from 9:00 a.m. to 4:30 p.m., except State holidays, or dhhs.HIPAAOffice@nebraska.gov for further information about the complaint process. To file a complaint with HHS, contact: **Secretary, Health and Human Services, Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 1-866-OCR-PRIV (627-7748). You will not be penalized for filing a complaint.**

Changes to the Notice of Information Practices

The State of Nebraska Department of Health and Human Services reserves the right to amend this Notice at any time in the future. Until such amendment is made, DHHS is required by law to abide by the terms of this Notice. DHHS will provide notice of any material change in revision of these policies.

Contact Information

dhhs.HIPAAOffice@nebraska.gov

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