Department of Health and Human Services

Application for Economic Assistance Benefits

If you need assistance completing this application: Call the ACCESSNebraska Customer Service Center at 1-800-383-4278; In Lincoln, call 402-323-3900; In Omaha, call 402-595-1258. If you completed a printed version of the application, mail it to ACCESSNebraska, PO Box 2992, Omaha, NE 68172; or fax it to: 402-595-1901; or email a scanned, completed application to: DHHS.ANDICenterOmaha@nebraska.gov	For Office Use Only: Date Stamp:________________ Case Number:_______________

Economic Assistance Programs (Abbreviations for these programs will be used throughout this application.)	**Please check the programs you want to apply for:**
Supplemental Nutrition Assistance Program (SNAP) – Food assistance to households with limited assets and income to buy the food they need for good nutrition. If applying for SNAP benefits only, please answer all questions noted with the 🍎.	☐
Aid to Dependent Children (ADC) – Cash assistance to eligible parents and dependent children age 18 or younger who qualify because the family has little or no income. Participation in Employment First (EF), a work readiness program, may be required.	☐
Low Income Home Energy Assistance Program (LIHEAP) – Assistance to eligible households in paying for some winter heating bills, utility shutoffs, empty or low heating fuel tanks, utility deposits or summer cooling bills. Payments are made to utility providers to apply to the household's bill.	☐
Child Care Subsidy (CC) – Assistance to eligible parents and caretakers in paying for the cost of child care while they work, attend employment-related training or school, or participate in another approved activity. Based on their income the family may be responsible to pay for a portion of the cost.	☐
Refugee Resettlement Program (RRP) – Medical assistance to persons who are not eligible for other programs to achieve economic self-sufficiency. Assistance may be available to single adults or childless couples in the first 8 months after their arrival in the United States.	☐
Assistance to the Aged, Blind and Disabled (AABD) payment – Cash assistance to income eligible individuals or couples who are age 65 or older, or have been determined to be permanently and totally disabled or blind.	☐
State Disability Program (SDP) – Medical coverage to individuals who are under age 65 and have been denied by Social Security Administration for "lack of duration" and been determined temporarily disabled for at least 6 months but not more than 12 months. Individuals cannot be eligible for Medicaid and the SDP at the same time.	☐
Social Services Block Grant (SSBG) – Assists with services for an eligible individual or household to achieve self-support. This includes household chores (like preparing meals, buying meals, etc.), transportation, adult day care and homemaker education.	☐

🍎 1. **Applicant Information/Head of Household:** If your household has more than one parent, you must tell ACCESSNebraska which parent should be designated as "Head of Household." In households without children, the "Head of Household" must be the person who has the greatest amount of earned income in the previous two months.
DHHS will use the person listed here as the head of household.

Your Legal First Name	M.I.	Legal Last Name	Social Security No.	Date of Birth

Home Address (Number, Street, Apt. Number)	City	State, Zip Code	Home or Cell Phone
Mailing Address (if different from above)	**City**	**State, Zip Code**	**Best time to call you for an interview**
Previous Addresses in last 30 days	**City**	**State, Zip Code**	**E-Mail Address**

I state under penalty of perjury, that I have completed the application to the best of my knowledge and my answers are true and correct. I authorize the release of information to DHHS. The requested information will be used only in the administration of economic assistance programs and will not be released to any other person or agency outside of DHHS, except I understand 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 my household. I read, understand, and agree to the "What I Should Know" section which is located on the last pages of this document.

🍎 Your Signature	Date	Spouse's/Co-Applicant's Signature, if Applying	Date
🍎 **Authorized Representative, Conservator, Guardian Printed Name**		🍎 **Authorized Representative, Conservator, Guardian Signature**	🍎 **Date**
🍎 **Person Who Helped Complete Application If Not Listed Above**			

- **You or your representative may submit an application with only your name, address, and signature on page 1. However, if you complete the entire application, benefits may be able to be more quickly processed.**
- If you are applying for SNAP and are receiving or have applied for Supplemental Security Income (SSI) while in an institution, the date of the application will be the date of release from the institution.
- Households not eligible for expedited service may receive SNAP benefits within 30 days from when the application is received by DHHS.
- Households eligible for expedited service may receive SNAP benefits within 7 days from when the application is received by DHHS.

2. Do you need an interpreter? ☐ Yes ☐ No
What language?

3. Are you homeless?
☐ Yes ☐ No

4. Are you a resident of Nebraska?
☐ Yes ☐ No

5a. **Is your household's gross income (what you earn before payroll deductions) for this month less than $150?** ☐ Yes ☐ No

5b. **What is the monthly part/amount of your rent or mortgage that you pay?**

5c. Is this public/subsidized (section 8) housing?
☐ Yes ☐ No

5d. **Are your total household cash/savings for this month less than $100?** ☐ Yes ☐ No

5e. **Is your household's gross monthly income plus your resources less than your monthly rent or mortgage and utilities?**
☐ Yes ☐ No

5f. Is anyone in your household a migrant or seasonal farm worker whose cash and savings are $100 or less AND whose income has recently stopped?
☐ Yes ☐ No
If yes who:

6. Do you have an eviction notice?
☐ Yes ☐ No

7. Check the bills you pay:
☐ Electricity ☐ Gas ☐ Water & Sewage ☐ Phone

7b. Have your utilities been shut off or do you have a shut off notice? ☐ Yes ☐ No

7c. Do you or anyone in your household receive a bill or pay for heating and/or cooling (air conditioner)? ☐ Yes ☐ No

7d. If yes, which of the following is your main source of heating and/or cooling? ☐ Natural Gas ☐ Electric/Heating ☐ Electric/Cooling ☐ Propane ☐ Coal, Fuel Oil, Kerosene or Wood/Other Sources

7e. Heating provider name	Heating provider address	Heating provider account no.
7f. Cooling provider name	Cooling provider address	Cooling provider account no.

7g. Did your household receive LIHEAP in the last 12 months?
☐ Yes ☐ No

8. Do you have a Nebraska Electronic Benefits Transfer (EBT) card for SNAP Benefits? ☐ Yes ☐ No

Have you ever had an EBT card? If question is not answered, DHHS will take as declaration that you have a card. ☐ Yes ☐ No

9. Do you have a Nebraska US Bank ReliaCard for LIHEAP, ADC, AABD or RRP grant? ☐ Yes ☐ No

Have you ever had an Relia card? If question is not answered, DHHS will take as declaration that you have a card. ☐ Yes ☐ No

10. **Household Information: If you need extra space in the following sections, please attach extra pages. Please provide as much information as possible to help us determine your eligibility quickly.** Please list yourself and everyone living in your home, even if you are not applying for everyone. Social Security numbers and citizenship status are only required for those for whom you are applying. Gender and Marital Status are not required for SNAP.

List everyone living in your home:

Legal Name (First, Middle, Last)	Relationship to You	Birthdate	Male/ Female (M/F)	Social Security Number (see above)	Does This Person Want Benefits	U.S Citizen	Marital Status	Does This Person Buy & Eat Food with You
	Self				☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No
					☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No
					☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No
					☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No
					☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No

11. Do any of the children living in the home have a parent living outside the home? ☐ Yes ☐ No

Name of Parent	Address	Phone	Name of Child	Other information you can provide such as the parent's employer or address

12. Is anyone in the home pregnant? ☐ Yes ☐ No If yes, please complete below.

Who is pregnant?	What is the due date?	List the name of the father

13. Please mark your living arrangement:

- ☐ Live in a house – rent/own mortgage
- ☐ Rent an apartment, duplex, triplex
- ☐ Drug abuse or alcohol treatment center
- ☐ Rent a room
- ☐ Board and room situation
- ☐ Center for developmentally disabled
- ☐ Assisted living
- ☐ Nursing home
- ☐ Drug abuse or alcohol treatment center
- ☐ Domestic violence shelter
- ☐ Group home, foster care, child care institution, adult family home
- ☐ Other: ___________________________________

14. Is any household member temporarily out of the home in a facility (such as a nursing home, hospital, mental health institution, or group home)? ☐ Yes ☐ No If yes, please complete below.

Date Entered	Name and Type of Facility	Phone

15. Is anyone in the home currently in foster care or has ever been in foster care? ☐ Yes ☐ No
If yes, who?

16. Has anyone in the home received food or cash assistance from another state or source in the last 30 days?
☐ Yes ☐ No If yes, who? If another state, list state, county and city:

17. Please complete the following section for all non-citizens in the home who are applying for benefits. Include a copy of the front and back of your U.S. Citizenship and Immigration Services (USCIS) card. If the non-citizen has a sponsor, please provide the information asked for below. If you need extra space in the following sections, please attach pages. Your alien status may be subject to verification by USCIS. The submitted information received from USCIS may affect your eligibility or level of benefits.

Name of Non-Citizen[1]	Alien Number
Does the non-citizen receive free room and board? ☐ Yes ☐ No	Does the non-citizen live with his or her sponsor? ☐ Yes ☐ No
Document Type (such as I-94)	Is the non-citizen's spouse or parent a veteran or an active-duty member of the US military? ☐ Yes ☐ No
Document ID Number	Has this person lived in the US since 1996? ☐ Yes ☐ No

Sponsor('s) Social Security No.	Sponsor('s) Address	Sponsor('s) Phone Number

Name of Non-Citizen[2]	Alien Number
Does the non-citizen receive free room and board? ☐ Yes ☐ No	Does the non-citizen live with his or her sponsor? ☐ Yes ☐ No
Document Type (such as I-94)	Is the non-citizen's spouse or parent a veteran or an active-duty member of the US military? ☐ Yes ☐ No
Document ID Number	Has this person lived in the US since 1996? ☐ Yes ☐ No

Sponsor('s) Social Security No.	Sponsor('s) Address	Sponsor('s) Phone Number

GENERAL INFORMATION

Has anyone in the household been:

18a. Hiding or running from the law to avoid prosecution, being taken into custody, or going to jail for a felony crime or attempted felony crime, or violating a condition of parole or probation? ☐ Yes ☐ No	If yes, who?
18b. Charged and convicted of a felony (after 8/22/96) for possession, sale, use or distribution of a controlled substance? A "controlled substance" is an illegal drug or certain drugs that require a doctor's prescription. ☐ Yes ☐ No	If yes, who?
18c. Convicted of using and/or receiving or attempting to use and/or receive SNAP benefits in exchange for firearms, ammunition, or explosives (after 9/22/1996)? ☐ Yes ☐ No	If yes, who?
18d. Convicted of fraudulently receiving or attempting to fraudulently receive duplicate SNAP benefits in any state (after 9/22/1996)? ☐ Yes ☐ No	If yes, who?
18e. Found guilty of buying or selling or attempting to buy or sell SNAP benefits of $500 or more (after 9/22/1996)? ☐ Yes ☐ No	If yes, who?
18f. Found to have misrepresented identity or residence or attempted to misrepresent identity or residence in order to obtain multiple SNAP benefits at the same time (after 9/22/1996)? ☐ Yes ☐ No	If yes, who?
18g. Convicted of trading or attempting to trade SNAP benefits for drugs (after 9/22/1996)? ☐ Yes ☐ No	If yes, who?
19. Disqualified in one of the following programs: ADC/SNAP/CC (Example of disqualification: being found through an administrative hearing or court of law to have intentionally provided false information.)? ☐ Yes ☐ No	If yes, name of disqualified person.

What state?	When (month and year)?	How long were they disqualified (6 mo., 1, 2, 10 years or permanently)?

20. Found to have misrepresented identity or residence or attempted to misrepresent identity or residence in order to obtain multiple ADC benefits at the same time (after 9/22/1996)? ☐ Yes ☐ No	If yes, who?
21. Is anyone in the home a veteran, spouse of veteran or a minor child of a veteran? ☐ Yes ☐ No	If yes, who?
22. Is anyone in the home a victim of human trafficking? (Victims of human trafficking are people taken, kept, or moved by force or fraud for sexual exploitation or forced labor.) ☐ Yes ☐ No	If yes, who?
23. Is anyone in the home receiving Native American Tribal Commodities? ☐ Yes ☐ No	If yes, who?

24. Does anyone in the home attend high school, vocational school or college? ☐ Yes ☐ No If yes, please complete below.

Name of Person	Name of School and Location	Last Grade Completed	Expected Date of Graduation	Enrollment Status	Hours per Week

25. Does anyone in your household receive Medicare (Social Security)? ☐ Yes ☐ No
If yes, please provide the name and medicare claim number below of that person:

Name	Medicare Claim Number

26. Has anyone in the home been determined disabled by the Social Security Administration? ☐ Yes ☐ No

27. Has anyone in the home been denied benefits by the Social Security Administration? ☐ Yes ☐ No If yes, please complete below.

Was this person denied for duration (meaning the disability would not last longer than 12 months)? ☐ Yes ☐ No

Are you requesting medical coverage for this person? ☐ Yes ☐ No

Does this person need help paying medical bills incurred within the last 3 months? ☐ Yes ☐ No

28. Does anyone in the home have a disability? ☐ Yes ☐ No If yes, does this person need help with self-care activities (such as bathing, dressing, eating, etc.)? ☐ Yes ☐ No

29. Is anyone in the household an able-bodied adult refugee, or other alien, with no children and with a status date within the past 8 months? ☐ Yes ☐ No If yes, are you requesting medical assistance? ☐ Yes ☐ No

30. Do you want to choose a person to apply for SNAP benefits on your behalf?
☐ Yes ☐ No If yes, please provide the name/address/phone number below of that person:

Name	Address	Phone Number

31. Do you want to choose a person to use your SNAP benefits with your electronic benefits transfer (EBT) card on your behalf? ☐ Yes ☐ No

If yes, please provide their name/address/phone number below:

Name	Address	Phone Number

32. Does anyone in the home receive or has applied for help to have a guardian, conservator, or individual acting under Power of Attorney? ☐ Yes ☐ No If yes, provide supporting documents and their contact information.

Name	Address	Phone Number

If Applying for Child Care Subsidy:

33a. In order to receive Child Care Subsidy, do you agree to have your child(ren) receive shots to protect against diseases (such as measles, chicken pox) or infection in accordance with State of Nebraska immunization guidelines?
☐ Yes ☐ No If no, please check the reason below:

33b. ☐ My religious beliefs do not allow shots; or
☐ These shots would harm my child's medical condition. (This requires a doctor's statement).

33c. Does your child care provider accept child care subsidy? ☐ Yes ☐ No	If no, do you need assistance in finding a provider? ☐ Yes ☐ No
If yes, please list the name of your child care provider	Provider number (if known)

33d. What is the reason you need Child Care Subsidy and how many hours do you need? (You may be asked to provide verification to support the reason you need Child Care.)

Reason you need Child Care	Hours needed per week:

Income - Use more paper if there is not enough room for your answers on this application

34. Is anyone in the home working? ☐ Yes ☐ No If yes, please complete lines below and include the last 30 days of income (before taxes and deductions) or proof of employment such as a pay stub or stubs. If you did not provide your Social Security Number, please include proof of employment.

Current Job 1: Name of person who is working	Employer name and phone number
Monthly wage/tips (before taxes) Hourly rate:	Is this job considered temporary and expected to last less than 3 months? ☐ Yes ☐ No
Average hours this person worked each week	How often is this person paid? ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

Current Job 2: **Name of person who is working**		**Employer name and phone number**
Monthly wage/tips (before taxes) Hourly rate:	Is this job considered temporary and expected to last less than 3 months? ☐ Yes ☐ No	
Average hours worked each week	How often is this person paid? ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly	

Current Job 3: **Name of person who is working**		**Employer name and phone number**
Monthly wage/tips (before taxes) Hourly rate:	Is this job considered temporary and expected to last less than 3 months? ☐ Yes ☐ No	
Average hours worked each week	How often is this person paid? ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly	

35. Complete this box if: anyone in your household has a home business; anyone sells things online or websites such as eBay or Craigslist; anyone is self-employed; or if anyone earns money by baby sittiing, donating plasma, or selling goods such as make-up or kitchenware.

Who is self-employed	Name of business	Is business a corporation or LLC? ☐ Yes ☐ No
Last month's gross income of this business $	Last month's net income of this business $	Last month's business costs $
Describe last month's business costs. (This includes things like advertising or supplies.)		

36. Has anyone in the home quit, ended a job, or have hours reduced in the past 30 days? ☐ Yes ☐ No
If yes, please complete below:

Name of person who quit or lost a job	Employer name and phone number
Date and amount of this person's last paycheck	Monthly wages/tips (before taxes)
Reason this person's job ended	
Start and end date of job	How often was this person paid? ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

37. Is any household member on strike? ☐ Yes ☐ No

38. Have you or anyone in your home applied for or received other income? ☐ Yes ☐ No
If yes, check all sources of income that apply and complete below:

- ☐ Unemployment Benefits
- ☐ Child Support
- ☐ Retirement/Pension
- ☐ Social Security Benefits
- ☐ SSI
- ☐ Survivor Benefits
- ☐ SSDI
- ☐ Veterans Benefits
- ☐ Veteran Widow
- ☐ Dividends/Interest
- ☐ Alimony
- ☐ Loans/Gifts
- ☐ Rental Income
- ☐ Disability Benefits
- ☐ Financial Aid
- ☐ Public Assistance
- ☐ Railroad Retirement
- ☐ Worker's Compensation
- ☐ In-Kind Income (working for rent)
- ☐ Other Cash Received Monthly

Person Getting Money	**Source of Income**	**Monthly Amount**
		$
		$
		$

39. Has anyone who is applying received a lump sum payment? (Lawsuit or insurance settlement, Social Security, SSI, SSDI, Veterans Benefits, inheritance, surrender of annuity, or life insurance, other). ☐ Yes ☐ No If yes, please complete below.

Who	**When received**	**Type of lump sum**	**Amount $**
Who	**When received**	**Type of lump sum**	**Amount $**

Resources - For all questions in this section, you must include resources jointly owned with household and non-household members.

40a. Do you or anyone in the home have any of the following: ☐ Yes ☐ No If yes, check all that apply below and answer the following questions.

- ☐ Cash
- ☐ Checking and Saving Accounts
- ☐ Certificates of Deposits (CD)
- ☐ Proceeds from Sale of Home(s)
- ☐ Mutual Funds
- ☐ Inheritance
- ☐ 401(K)
- ☐ Other Resources
- ☐ Retirement Accounts
- ☐ Stocks /Bonds
- ☐ Annuities
- ☐ Education Accounts
- ☐ Property (Land, Homes)
- ☐ Trusts

Person Who Has It	What Do They Have?	Amount	Person Who Has It	What Do They Have?	Amount
		$			$
		$			$
		$			$

40b. Does anyone own a car, truck, van, boat, motorcycle, RV, or trailer? ☐ Yes ☐ No
If yes, list them below. Licensed and unlicensed items must be listed.

Person Who Owns It	Make/Model and Year	Value
		$
		$
		$

40c. Has anyone given away anything of value or sold anything for less than fair market value in the last five years? If applying for SNAP, include anything within the past three months. ☐ Yes ☐ No
If yes, list what was sold or given away below:

Person Who Gave it Away or Sold It	What Was Given/Sold?	Value
		$

40d. Is anyone buying or does anyone own land, a property, a house, a rental property, a timeshare, a cabin, or a lot in Nebraska or anywhere? ☐ Yes ☐ No If yes, list them below:

Person Who is Buying/Owns	Address or Property Description	Value
		$

41. Does anyone have life insurance policies? ☐ Yes ☐ No List policies below:

Who owns this policy?	Company and Policy Number	Whole Life or Term	Value
			$
			$

42. Does anyone have burial insurance policies? ☐ Yes ☐ No List policies below:

Who owns this policy?	Company and Policy Number	Whole Life or Term	Value
			$
			$

Expenses - Failure to report or verify an expense other than rent and utilities will be seen as a statement by your household that you do not want us to count this expense. This may result in you getting a lower amount of SNAP benefits.

43a. Does anyone pay child care or adult daycare?

Expense	Who Pays Expense?	Who it is for	Amount Paid	How often Paid
			$	
			$	
			$	

43b. Does anyone pay alimony (alimony does not apply to SNAP) or child support? This includes any arrearages (back payments).

Expense	Who Pays Expense?	Who it is for	Amount Paid	How often	Legally Obligated Amount
			$		
			$		

43c. Does anyone pay medical expenses (such as insurance, premiums, prescription medicines or co-pays)? For SNAP, the expense can only be used if it is paid by an elderly or disabled household member.

Expense	Who Pays Expense?	Who it is for	Amount Paid	How often Paid
			$	
			$	
			$	

44. Does anyone pay a second mortgage, lot rent, condominium fees, property taxes on your home (not included in rent) or homeowners insurance (not included in rent)? ☐ Yes ☐ No If yes, please complete below.

Expense	Amount currently billed	How often billed?
	$	

45. Have you received help paying for one of the expenses above in the last 12 months? ☐ Yes ☐ No

If yes, who helped pay the above expenses?

Voter Registration

Any citizen in the State of Nebraska who has met the voter registration requirements and applies for economic assistance benefits must be provided the opportunity to register to vote. If you would like help in filing out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application in private. If you are not registered to vote where you live now, would you like to apply to register to vote today*? ☐ Yes ☐ No

**If you did not check either answer, you will be considered to have decided not to register to vote at this time.*

OPTIONAL Race and Ethnicity

Indicate the race and ethnic category of the head of household. Title VI of the Civil Rights Act of 1964 allows us to ask for this information. This information will not be used in determining eligibility for assistance. If you do not provide this information, it will not affect your application. We ask for the information to assure benefits are distributed without regard to race, color, national origin, age, disability, sex, gender identity, religion, reprisal and where applicable, political beliefs, marital status, familial or parental status, sexual orientation or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the department. If you do not enter any information, the worker will enter an answer.

Race: Select all that apply

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other:___________________

Ethnic Category – Are you Hispanic or Latino? ☐ Yes ☐ No

For information regarding resources in your area, please call 2-1-1 from a landline phone, or 402-444-6666 from a cellular phone.

If you want to apply for Child Support Enforcement (CSE), please go online and apply at: dhhs-childsupport.ne.gov/CSENPAApp/ or call 1-877-631-9973, option 2.

WHAT SHOULD I KNOW

(Rights and Responsibilities)

PLEASE KEEP THIS FOR YOUR INFORMATION

By completing and signing the Nebraska Economic Assistance Application for Benefits (EA-117) and other documents required to determine whether I am eligible for economic assistance benefits AND by accepting benefits that I am eligible to receive, I understand the following information and agree to the following requirements.

- I must tell the truth. It is a crime to lie on this application.
- I may have to give papers that show what I have told you is true.
- I may have to tell you of any changes to the information I gave you on my application.
- If I think DHHS made a mistake, I can ask for an appeal or fair hearing.
- DHHS will not discriminate.
- DHHS will confirm citizenship and immigration status for everyone applying for benefits.
- DHHS will take back any benefits you should not have received.
- DHHS will tell you when your benefits will decrease or be terminated.

YOU HAVE THE RIGHT TO

- Apply and discuss any action taken on your application or case with a worker or a 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 to you.
- Have your application for SNAP processed in accordance with SNAP procedures, including procedures based on timely processing and notice requirements.
- Have your application for SNAP benefits considered, regardless of whether or not you have been denied benefits from other programs.

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.
- Pay a fee to your child care provider if required to do so based on your income.
- Cooperate with state and federal personnel in a Quality Control review.
- Cooperate with Nebraska Managed Care Program for certain recipients of medical services.
- Cooperate with Nebraska Child Support Enforcement.
- Ask questions if you do not understand something about medical assistance.

REPORTING CHANGES FOR AABD, ADC, SDP, RRP AND CHILD CARE SUBSIDY PROGRAMS

Report all changes within 10 days to DHHS such as:

- Changes in the household, such as when 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, (such as getting a new vehicle or a change in your bank account).

You may report these changes online: www.ACCESSNebraska.ne.gov. Click on "Report Changes."

REPORTING CHANGES FOR SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP) BENEFITS FORMERLY KNOWN AS FOOD STAMP PROGRAM

There are three reporting categories in SNAP. Change Reporting (CR), Simplified Reporting (SR), and Transitional Benefits Reporting (TBR). The reporting category to which you will be assigned is determined by your household situation. You will be informed of the reporting category, certification period and reporting requirements on your Notice of Eligibility. You will receive the Notice of Eligibility by mail. If your SNAP benefit reporting category changes during the certification period, you will receive another notice with the new reporting requirements for the new category. If you have any questions, or need help understanding your notice or reporting category, contact DHHS or go online at: www.ACCESSNebraska.ne.gov and select "Report Changes."

RESTRICTIONS ON THE USE OF ELECTRONIC BENEFITS

NOTICE: If you receive your TANF (Temporary Assistance for Needy Families - ADC, AABD, SDP, RRP or LIHEAP) benefits via the ReliaCard-debit card, please know that it is a violation of federal law and/or state regulation to access these funds from an ATM located at or via a point-of-sale purchase at the following types of businesses:

1. Liquor stores;
2. Casino, Gambling Casino or Gaming Establishment; or
3. Any retail establishment which provides adult-oriented entertainment in which performers disrobe or perform in an unclothed state for entertainment.

NEBRASKA LOW INCOME HOME ENERGY ASSISTANCE PROGRAM (LIHEAP)

LIHEAP payments will be sent to utility providers. If a household receives LIHEAP payments directly, they must agree to take full responsibility for paying utility bills.

AID TO DEPENDENT CHILDREN (ADC) AND CHILD CARE PENALTY WARNING

Individuals who have knowingly provided false information in order to qualify for ADC or Child Care subsidy benefits may be subject to disqualification due to an Intentional Program Violation (IPV). For the ADC Program, only the individual found to have committed the IPV shall be disqualified. For the Child Care subsidy, the individual found to have committed the IPV and his/her family shall be disqualified. The period of disqualification shall be:

a. For a first violation, up to one year;
b. For a second violation, up to two years;
c. For a third violation, permanent disqualification.

These penalties shall also be imposed if an individual is found by a court to have violated Neb. Rev. Stat. § 68-1017.

ADC WORK REQUIREMENTS

If you receive ADC cash assistance, you must participate in approved work activities unless you qualify for an exemption. If you do not cooperate with the work requirements, your benefits may be reduced or ended. ADC recipients will be required to develop and sign an individualized Self-Sufficiency Contract that will identify the goals and list the steps necessary to become economically self-sufficient.

SNAP WORK REGISTRATION

The signature of the "Head of Household," other adult in the household, or an authorized representative on this application constitutes registering for work of all non-exempt household members.

SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP) PENALTY WARNING

The information provided on this application is subject to verification by federal, state and local officials. If any is found inaccurate, participation in SNAP may be reduced, terminated or denied.

Individuals who have knowingly provided false information may be subject to criminal prosecution. Any member of a household who breaks any of these rules on purpose may be barred from SNAP for 12 months for the first violation, 24 months for the second violation, and permanently for the third violation. Additionally, individuals may be fined up to $250,000, imprisoned for up to 20 years, and subject to prosecution under other applicable federal laws. A court can also bar an individual from the program for an additional 18 months. Individuals convicted of trafficking benefits for an aggregate amount of $500 or more will be permanently ineligible to participate in SNAP upon the first occasion of such violation. Individuals found guildy of using and/or receving and/or attempting to use and/or receive SNAP benefits in exchange for firearms, ammunition or explosives, will be permanently ineligible for SNAP upon the first occassion of such violation.

DO NOT:

- **Give false, incorrect, or incomplete information to attempt to obtain or continue to obtain SNAP benefits.**
- **Trade or sell or attempt to trade or sell SNAP benefits or Electronic Benefits Transfer (EBT) cards.**
- **Use other people's SNAP benefits or EBT cards unless designated.**
- **Use SNAP benefits to buy nonfood items, such as alcohol, or cigarettes, or to pay on credit accounts.**
- **Use SNAP benefits to buy illegal drugs, firearms, ammunition, or explosives.**

Individuals found guilty in federal, state, or local court of offenses listed in questions 18a - 18f on page 4 on the EA-117, will be disqualified from participating in the Supplemental Nutrition Assistance Program (SNAP).

Individuals found guilty in federal, state, or local court for the offense listed in 18f will be disqualified for 10 years for the first and second offenses and permanently for the third offense.

Individuals found guilty in federal, state, or local court for offense in question, 18g will be disqualified from participating in the SNAP for one year after the first offense and permanently for a second offense.

CHILD CARE SUBSIDY PROGRAM

The purpose of the Child Care Subsidy Program is to assist low income families with child care. The Child Care Subsidy Program is governed by Nebraska Department of Health and Human Services, Nebraska Administrative Code (NAC) Title 392. Child Care will only be provided if the household meets the program requirements that have been established by Title 392. The parent is responsible to report any changes (as listed on page I) and it is not the responsibility of the child care provider. Child care can only be used for the purpose authorized. If you use child care for another purpose, you may be required to repay DHHS for the unauthorized care.

FAIR HEARINGS

If you disagree with any action taken by the Nebraska Department of Health and Human Services (DHHS) which affects your benefits, you may request a fair hearing in writing. Fair hearing for SNAP can be requested verbally by contacting DHHS. You may continue to receive your current level of assistance until a hearing decision is made IF (1) you request a hearing within 10 days from the mail date listed on an agency notice, and (2) for SNAP benefits only, your certification period has not expired. 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

The United States Department of Agriculture (USDA) prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.) If you wish to file a Civil Rights program complaint of discrimination with USDA, complete the USDA Program Discrimination Complaint Form found online at **http://www.ascr.usda.gov/complaint_filing_cust.html**, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter by mail to U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W. Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at **program.intake@usda.gov**.

Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Services at (800) 877-8339; or (800) 845-6136 (Spanish). For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, person should either contact the USDA SNAP Hotline Number at (800) 221-5689, or call the State Information/Hotline Numbers; found at **http://www.fsn.usda.gov/snap/contact_info/hotlines.htm**.

VOTER REGISTRATION

Please note that the information and office to which application was made will remain confidential and be used only for voter registration purposes. Applying to register or declining to register to vote will not affect the amount of assistance or services that you will be provided by this agency. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the:

Nebraska Secretary of State
State Capitol Building
Lincoln, Nebraska 68509-4608
Telephone (402) 471-2554

SOCIAL SECURITY NUMBER

DHHS asks for Social Security Numbers (SSNs) of all individuals for whom assistance/benefits is requested. Individuals who are not applying for assistance for themselves are not required to have or provide a SSN. If the individual is financially responsible for others in the household, the SSN will be used only to verify income and/or resources through computer matches as listed below or other contacts so that eligibility can be determined for those requesting assistance. If the SSN is not provided, the household must assume responsibility for providing the information needed to determine eligibility for the individuals requesting assistance. Any SSNs provided will be used and disclosed in the same manner as SSNs of eligible participants. For SNAP benefits, SSNs may be disclosed to other federal and state agencies for official examination and to law enforcement officials for the purpose of apprehending persons fleeing to avoid the law. If a household has a SNAP benefit overpayment, the information on this application, including the SSNs, may be referred to federal and state agencies as well as private collection agencies for overpayment collection action.

The SSN of each person in the household who is applying for assistance and provides his/her SSN will be computer matched with the following agencies to assist in the determination of eligibility: Income and Eligibility Verification System, Nebraska Department of Health and Human Services, Nebraska Department of Labor, Social Security Administration, Clerk of the District Court, Child Support Payment Center, Internal Revenue Service, and Veterans' Administration.

The information received from these agencies is used and verified when discrepancies are found by DHHS; this information may affect the household's eligibility and level of benefits. SSNs are also used in computer matching and program reviews or audits to make sure each household gets the correct amount of benefits. This may result in criminal or civil action or administrative claims against persons fraudulently participating. This information will also be used to monitor compliance with program requirements and for program management.

Child Care Subsidy and Social Services Block Grant do not require a SSN to apply for these programs and eligibility will not be denied if SSNs are not provided. If an SSN is provided, it will be used to assemble research data sets that do not identify individuals and to verify income.

If you are applying for SNAP benefits, or Child Care Subsidy, this application asks you to tell us about the citizenship and immigration status of people in your household. For Child Care Subsidy, you must tell us about the citizenship or immigration status for the children who will receive assistance. If anyone in your household doesn't have a SSN, we can help them apply for one and your application will not be delayed.

Only those people who provide information regarding their immigration status and SSNs can receive SNAP benefits. If some family or household members do not wish to apply for SNAP benefits, they do not need to provide this information. If people in your household choose not to give us information about their immigration status or SSN, they must still provide us the information needed to determine the eligibility of the other persons in your household. You may withdraw your request for benefits for these persons or you may withdraw your entire application.

SDP AND RRP MEDICAL

Third Party Liability: Individuals who receive Medical Assistance 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 payments 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 any time you want to claim good cause, you must tell DHHS that you think you have good cause. Good cause is a finding by DHHS that cooperation is against the best interests of the chid 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 persons. 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 recipients must release them to DHHS. This information will be used as provided in the Notice of Information Privacy Practices.

Medical Reimbursement Agreement: When DHHS pays for a recipient's services, 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 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.

Medical Services:

- Present proof of your current eligibility to medical providers before obtaining services.
- Ask your medical provider or DHHS about which services are covered.
- Inform DHHS 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 costs 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 that your coverage is through DHHS.
- Failure to follow certain conditions may result in your being responsible to pay the bills.

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 Sate 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.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Nebraska Department of Health and Human Services (DHHS) and those agencies inclusive of health care facilities and medical assistance programs that are affiliated under the common control of the 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 without your consent for purposes of:

- Treatment: We may use your medical information to provide you with medical treatment or services. We may share your information with a nurse, medical professional or other personnel who are giving you treatment or services. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. Different agencies within DHHS may share your medical information in order to coordinate the different things you need, or to support and maintain your continuum of care.

- 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 the hospital can be reimbursed.
- Operations: We may use and disclose medical information about you for health care 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/AUTHORIZATION:

- 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 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: 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.
- Specialized Government Functions: When the appropriate conditions apply, we may use or disclose Protected Health Information of individuals who are Armed Forces personnel for military, national security, and intelligence activities. Protected Health Information may be disclosed for the administration of public benefits purposes.
- 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: 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.

USES AND DISCLOSURES REQUIRING AUTHORIZATION:

There are certain uses and disclosures of Protected Health Information that require your authorization. Among them are: most uses and disclosures of psychotherapy notes; uses and disclosures of protected health information for marketing purposes; and disclosure of protected health information that constitutes a sale.

Other uses and disclosures not described in this notice will be made only WITH authorization from you. You may revoke this authorization at any time as provided by 45 CFR 164.508(b)(5).

YOUR RIGHTS TO PRIVACY:

- Right to Inspect and Copy. You have the right to inspect and copy your medical information. Usually, this includes medical and billing records but does not include psychotherapy notes. To inspect and copy your medical information, you must submit a written request at the Site of Service or to the DHHS HIPAA Privacy & Security Office. If you request a copy, we may charge a fee for the cost of copying, mailing, and other supplies associated with your request. We may deny your request to inspect and copy in certain circumstances. If you are denied access to medical information, you may request the denial be reviewed.

- Right to Amend. If you feel that medical information about you is incorrect or incomplete, you may ask us to amend (correct) 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 DHHS HIPAA Privacy & 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 a list of the disclosures we made of medical information about you. You must submit your request in writing at the Site of Service, or to the DHHS HIPAA Privacy & Security Office. 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.
- 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, health care operations, and to someone who is involved in your care or the payment of your care, like a family member or friend. We are not required to agree to your request for restrictions unless it is for payment or health care operations and you use your own funds to pay, in full, for a health care item or service. 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 DHHS HIPAA Privacy & Security Office. 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.
- 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. To request confidential communications, you must make your request in writing at the Site of Service, or to the DHHS HIPAA Privacy & Security Office. Your request must specify how or where you wish to be contacted.
- Right to a Paper Copy of this Notice. You have a right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our website, http://dhhs.ne.gov/Pages/hipaa_hp-1-p-notice.aspx or by contacting us.
- Opt out of fund-raising communications. If DHHS should conduct fund-raising activities, you have a right to opt out of this communication.
- Breach notification. In the event DHHS breaches your unsecured protected health information as defined by HIPAA, you will receive notification of the breach.

COMPLAINTS

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 the DHHS HIPAA Privacy & Security Office. 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), 1-866-778-4989-TTY. You will not be penalized for filing a complaint. 6

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 either electronically or in paper format.

CONTACT INFORMATION

This notice fulfills the “Notice” requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Final Privacy Rule. If you have questions about any part of this Notice of Information Privacy practices or desire to have further information concerning information practices at DHHS please direct them to: HIPAA Privacy and Security Office, 301 Centennial Mall South 3rd Floor, Lincoln, NE 68509-5026, by phone at 402-471-8417, or by email to DHHS.HIPAAOffice@nebraska.gov . If you have question about your benefits call 800-383-4278.

Effective:9/23/2013

Please go to **http://dhhs.ne.gov/Pages/default.aspx** to download and print. On the DHHS Homepage - on the bottom right - click on Download Forms - select OK - search by form/document number - double click title to open document.