Need help completing a Children's Medical application?

1. Make sure you send in the following:

- Proof of U.S. citizenship or alien status only for the child(ren) in your household that are applying for medical assistance.
- Proof of income if employed, including:

One month of current pay stubs; or
A letter from your employer that shows your income for the past 30 days; or
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If you are self-employed, send in a copy of your signed federal tax return; or
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If you are a farmer or rancher, send in a copy of your signed 1040 and Schedule F; or
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If you are involved in a partnership or "S" corporation, send in a copy of your signed 1040 and Form 1065 or 1120S and Schedule K-1; or
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NOTE: If your federal tax return does not reflect a full year of self-employment income or you did not file a tax return, we will need verification of your self-employment income and expenses (examples: bookkeeping records/ledgers or an itemized statement).

- Proof of any health insurance
- Proof of health insurance premium
- Proof of child care expenses
- Completed application

2. Mail your completed application to:
Nebraska Children's Medical Programs
P. O. Box 85801
Lincoln, NE 68501-85801

Children's Medical Programs

Reaching for a healthy future[SM]

Department of Health & Human Services
DHHS
NEBRASKA

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Nebraska Department of Health and Human Services

APPLICATION FOR CHILDREN'S MEDICAL PROGRAMS

This application is available at **ACCESSNebraska.ne.gov**
If you need assistance with food, utilities, child care, or other needs go to **ACCESSNebraska.ne.gov**
This application is valid for children from birth through age 18 and is **not** to be used for adult pregnant women.
Answer the questions; those marked with an * are required for those applying for assistance.
Proof of U.S. citizenship or alien status and Social Security numbers are only required for the child(ren) applying for medical assistance.
This becomes a valid application once you enter your name, and address, sign the form and return it to a DHHS office.

1. Person applying for the child(ren):	*Relationship:	Social Security Number (Optional):
Address (Street, City, State, Zip Code):		Home Telephone Number:
Mailing Address, if different :		Work/Message Telephone Number:

2. If you need us to provide an interpreter, check here ☐ What language?_____

3. *List all children (under age 19) living at home full-time, applying for medical assistance. Include pregnant minors. Provide the following information:

Name (Last name, first name)	If pregnant, list expected due date. (Requires a doctor's note)	Social Security Number	Race	Birthdate	Gender M/F	Mother's Name (Last, first name)	Father's Name (Last, first name)	Attend School Yes	Attend School No
								☐	☐
								☐	☐
								☐	☐
								☐	☐

4. *Complete this section only for the children listed above. Attach another sheet if more space is needed.

Name (Last name, first)	I am a U.S. Citizen Yes	I am a U.S. Citizen No	If U.S. Citizen list where born	I am a qualified alien under the Federal Immigration and Nationality Act Yes	I am a qualified alien under the Federal Immigration and Nationality Act No	If qualified alien, list immigration status and alien number
	☐	☐		☐	☐	
	☐	☐		☐	☐	
	☐	☐		☐	☐	

NOTE: If a qualified alien - I agree to provide a copy of the USCIS documentation to the Department of Health and Human Services upon request.

5. List everyone in your family that lives with you (parents & children not listed on page 1). Parents in home include Biological, Step or Adoptive. Use another sheet of paper if more space is needed.

*Name (Last, first, middle)	Social Security Number (optional)	Race	Birthdate (mm, dd, yy)	Gender M/F	*Pregnant Yes	No
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐

6. *Does anyone in your household have health, dental, vision or prescription insurance?
☐ Yes ☐ No If yes, send a copy of the insurance card (front & back), for all applicants, proof of the premium amount paid for **all** household members and provide the following information:

Insurance Company	Phone Number of Company	Premium Amount	Policy Number or Group Plan Number	Type of Coverage (HMO, full coverage, vision, dental, etc.)	Names of Family Members Covered by Policy

7. Did any of the children living with you have unpaid medical bills in the past 3 months?
☐ Yes ☐ No If yes, provide the following information:

Name of Child	What months

8. Do you or does anyone in your household work or receive money? Include work income for children who are not attending school. Work includes employment and self-employment. Self-employment could be farming, odd jobs, providing child care, housekeeping, etc.

Does any Adult or Child Currently Receive any Money from:	Yes	No	If yes, Who is it?	Employer Name or Income Source	Gross Amount (before deductions)	How often received?	Hourly Rate
Salaries, Wages, Tips, Commissions, etc., (Provide pay stubs for the last 30 days)	☐	☐		Business Name: Address:			
Salaries, Wages, Tips, Commissions, etc., (Provide pay stubs for the last 30 days)	☐	☐		Business Name: Address:			
If you were self-employed all of last year, provide a copy of your entire Federal Tax Return	☐	☐		Business Name: Address: Type of Business: Date Started:			
Child Support, Alimony/Spousal Support, Veterans' Benefits, Interest, Dividends, etc.	☐	☐					
Unemployment Compensation, Worker's Compensation, Social Security, SSI, etc.	☐	☐					
OTHER:_____	☐	☐					

NOTE: If your federal tax return does not reflect a full year of self-employment income or you did not file a tax return, we will need verification of your last three months self-employment income and expenses (examples: bookeeping records/ ledgers or an itemized statement).

9. Do you pay child care in order to participate in education, training or employment?
☐ Yes ☐ No If yes, provide the following information:

Name of Child	**Monthly Amount (must provide proof of amount paid per child)**	**Name, address and phone number of child care provider**

When this application is signed I agree that: For purpose of complying with Neb. Rev. Stat 4-108 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 the Department of Health and Human Services to use for the purposes mentioned in the Rights and Responsibilities.

Signature or Mark of Applicant: _____ Date:_____

Witness signature if mark:_____ Date:_____

Print name of person completing this form:

Mail this completed, signed form, together with requested proofs, to:
DHHS, P.O. Box 85801, Lincoln, NE 68501-85801.

If you need more information, please call toll-free 1-800-383-4278 or in Lincoln (402) 323-7455

ACCESS Nebraska

Department of Health & Human Services
DHHS
NEBRASKA

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 if required.
- 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 you are requested to do so by DHHS.
- Cooperate with state and federal personnel in a Quality Control review.
- Cooperate with Nebraska Managed Care Program for certain Medicaid recipients.
- Cooperate with Nebraska Child Support Enforcement if required.
- Ask questions if you do not understand something about any program requirements.

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 Medical can be requested verbally by contacting DHHS. You may continue to receive your current level of assistance until a hearing decision is made IF you request a hearing within ten days from the date of the agency notice. 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 / write 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). USDA and HHS is an equal opportunity provider and employer.

REPORTING CHANGES FOR MEDICAID
(This includes DHHS Children's Medical Program)

Report all changes within ten 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

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

SOCIAL SECURITY NUMBER / CITIZENSHIP

DHHS asks for Social Security Numbers (SSNs) of all individuals for whom assistance is requested as required by the federal Social Security Act. Individuals who are not applying for assistance for themselves are not required to have or provide an SSN. If the individual is financially responsible for others in the assistance unit, the SSN will be used 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 assistance unit 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.

The SSN of each person in the assistance unit 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, Child Support Payment Center, Internal Revenue Service, and Veterans' Administration.

The information received from these agencies is used and verified and 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.

This application asks you to tell us about the citizenship and immigration status of people in your household. For Children's Medical Programs, you must tell us the citizenship and immigration status for the children who will receive assistance. If an eligible household member doesn't have a SSN, we can help them apply for one and your application will not be delayed.

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 obtaining any available third party such as 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. 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 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 Medcaid 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.

Children's Medical Program:

- Present proof of your current medical eligibility to medical providers before obtaining services.
- Ask your medical provider or worker about which services are covered.
- Inform DHHS and your medical providers of any health insurance coverage you have (including dental and vision 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 through Nebraska Children's Medical Programs.

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

The Department of Health and Human Services promotes and values diversity. It is committed to affirmative action/equal employment opportunities and does not discriminate in delivering benefits or services.