Funding Services

Funding for the cost of home modifications, technology, or services needed by consumers who experience a disability are provided by numerous programs. The guidelines and eligibility requirements of those programs vary widely and are often overlooked as potential resources for those who are unfamiliar with how to access them.

The Assistive Technology Partnership's Resource Specialist will research the various programs across the state to determine a person's potential eligibility for funding assistance.

Families should list income of married couples or income of all adults, including wages of children ages 14-18.

The Process

1. The Service and Device Application is used to gather information about the services and/or devices needed. **Complete the Service and Device Application electronically or by mail:**

Electronically	Mail
• Request a fillable PDF application (email: atp.funding@nebraska.gov) • Complete, sign, and submit the application (you will receive a copy after submission)	• Print application, complete, and sign the application (keep first page for your records) • Mail the application to: Assistive Technology Partnership PO Box 94987 Lincoln, NE 68509-4987

2. The Resource Specialist will use the application information to identify the program(s) that are potential resources to cover or supplement the cost of the technology or services needed by the applicant.

3. The applicant will be notified of eligibility, and any necessary referrals will be made to the appropriate specialist, program, or service. This process takes about two weeks, but in some instances it may take longer.

   The application and release is valid for **one year** from date of signature.

Please note: Since funding is limited, eligibility does not always guarantee that funds will be available.

ATP ASSISTIVE TECHNOLOGY PARTNERSHIP

For more information on funding, call:
Assistive Technology Partnership
Toll Free (877) 713-4002

Service and Device Application

Clear Form

Date

Applicant Information

Name
Last First Initial

Parent/Guardian/Representative completing this form
Name **Phone** **Email**

Address **County**

City **State** **Zip Code**

Date of birth

Social Security #

Email Address

Phone
Home/Cell
☐ Text available
Work
☐ Text available

Male ☐ **Female** ☐ **Not identified** ☐

Veteran ☐

United States Attestation
For the purpose of complying with Neb. Rev. State §§ 4-108 through 4-114, I attest as follows:

☐ I am a citizen of the United States

☐ I am a qualified alien under the federal immigration and Nationality Act
Immigration status and alien number

Disability
Include health or medical impairments

Check all that apply:

☐ **Health Insurance Provider**

_____

☐ **Medicaid**

☐ **Medicare**

Medicaid Waivers:

☐ Aged and Disabled Waiver

☐ Developmental Disabilities Waiver

Services Coordinator

Name

Agency

Phone

Service and Device Application

Housing-check all that apply

- ☐ Home owner
- ☐ Renter
- ☐ Mobile Home ☐ Permanent Foundation
- ☐ Nursing home
- ☐ Foster home/adult family home
- ☐ Group home/community residence
- ☐ Living with adult/adult children
- ☐ Homeless
- ☐ Other

Services and equipment needed

Home Modifications

- ☐ Bathroom
- ☐ Entrance
- ☐ Equipment/Assistive devices
- ☐ Vehicle modification(s)
- ☐ Title in applicant's name
- ☐ Other

Check services you have received

- ☐ Area Agency on Aging
- ☐ Assistive Technology Partnership
- ☐ Commission for the Blind and Visually Impaired
- ☐ Commission for the Deaf and Hard of Hearing

Department of Health and Human Services

- ☐ Aid to Aged, Blind and Disabled
- ☐ Disabled Persons and Family Support
- ☐ Medically Handicapped Children Program
- ☐ Social Services Block Grant

- ☐ Hotline for Disability Services
- ☐ Housing and Urban Development/Section 203
- ☐ Independent Living Center
- ☐ League of Human Dignity-Barrier Removal Program
- ☐ Nebraska VR (Vocational Rehabilitation)
- ☐ Rural Development, Section 502 and 504
- ☐ United Cerebral Palsy of Nebraska
- ☐ Weatherization
- ☐ Other

Monthly out of pocket disability related expenses (medication, health related bills, special equipment):

Expense	Amount
_____	_____
_____	_____
_____	_____

Service and Device Application

Financial Information

List the amount of income you receive from each of the sources below. Single adults (19 years of age or older with no minor children) should list only your income. Families should list income of married couples or income of all adults, including wages of children ages 14-18.

Gross Income (before deductions)	Amount	How often received	Who receives it
Wages, overtime, bonuses, commissions, etc.			
Self-employment (use current IRS 1040)			
Interest dividends, investment income, capital gains			
Social Security Disability			
Social Security Income (SSI)			
Social Security Retirement			
Veteran Benefits			
Pensions			
Retirement, Keogh Accounts, IRA's, etc.			
Inheritance, estates, trust funds, etc.			
Aid to Aged, Blind, and Disabled (State supplemental check)			
Temporary Assistance for Needy Families (TANF)			
Alimony/Child Support			
Compensation (workers and unemployment)			
Rental income			
Other (insurance supplements, lottery winners)		Describe	

Assets

List all assets (e.g. cash, checking accounts, stocks, bonds, whole life insurance, certificates of deposit, farmland, etc.)

Type	Amount

Household members

Name	Relationship to applicant	Date of birth	Disabled
			☐
			☐
			☐
			☐

Service and Device Application

Release/Agreement Form

I verify that the information provided on this application is correct and complete.

I understand that whenever changes occur in the information provided, I need to report them immediately to the agency/agencies helping me with this request.

I understand I have the right to appeal if I am not satisfied with an agency's action.

I understand this is a multi-agency form. The agencies/programs listed below may contact each other to determine my financial eligibility for their programs and may verify my need of the support for which I have applied. I authorize the release of this information to be used for referrals/services for which it is determined I may be eligible. It is my understanding that this information will be held confidential by all those listed below.

Client Assistance Program Disability Rights Nebraska Easterseals Nebraska Hotline for Disability Services Independent Living Centers iCanConnect League of Human Dignity Muscular Dystrophy Association Nebraska Assistive Technology Partnership Nebraska Commission for the Blind and Visually Impaired Nebraska Commission for the Deaf and Hard of Hearing Nebraska Department of Health and Human Services	Nebraska Housing Developers Nebraska VR Project Houseworks Temporary Assistance for Needy Families (TANF) The Arc of Nebraska United Cerebral Palsy of Nebraska US Department of Agriculture (USDA) Veteran Programs Other:

Information may be released and shared on my behalf with the following family members and individuals:

_____

_____

Ethnicity/race (please check)

The following information is requested for Federal reporting purposes only. Your response is optional and will not affect your eligibility determination. Your assistance is appreciated.

☐ White (non-Hispanic)	☐ Black (non-Hispanic)	☐ American Indian/Alaskan Native
☐ Asian/Pacific Islander	☐ Latino	☐ Multi-Racial
Other		

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.

_____

Signature of applicant or guardian Date

Submit application: Assistive Technology Partnership PO Box 94987, Lincoln, NE 68509-4987 atp.funding@nebraska.gov	**Questions and more information:** (402) 471-0734 (877) 713-4002

Application and release valid for one year from date of signature.