NEBRASKA
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DEPT. OF HEALTH AND HUMAN SERVICES

Nebraska Department of Health and Human Services
Heritage Health Adult

Medically Frail Attestation Form

Purpose of Providing Attestation Form Information:
Nebraska DHHS MLTC uses this Attestation form to determine if the Heritage Health Adult Medicaid Expansion beneficiary is Medically Frail. Beneficiaries who are determined medically frail by DHHS will be enrolled in the HHA Prime benefit tier. Determinations for Medically Frail are effective for 12-months or 36-months before a redetermination is required.

Provider Instructions:
If you are a provider with diagnosing capabilities, within your Scope of Practice, and have a patient that you believe meets the Medically Frail criteria, as defined in the categories below, please complete this form. Incomplete forms will not be accepted.

Upload form to: http://dhhs.ne.gov/pages/accessnebraska.aspx

If you do not have internet access or if you have questions mail or E-mail form to:

Nebraska DHHS
Attention: Heritage Health Adult Medically Frail Determinations
301 Centennial Mall South, Lincoln, NE 68509
E-Mail: dhhs.medfrailreview@nebraska.gov

Beneficiary Information

Date Assessment Completed:	Medicaid ID:
Patient Name (Last, First, Middle Initial):	
Address:	
City, State, Zip Code:	Date of Birth:

Social Security Determination

Beneficiary Meets One of the Following Criteria or Has Documentation Supporting Medically Frail Attestation	Yes / No	Diagnosis or ICD-10 Codes (Required)
Has a current disability designation by the Social Security Administration standards.		
Has applied for, but not yet received a disability determination.		

Chronic Homelessness

Beneficiary Meets the Following Criteria	Yes / No
1. Has been continuously homeless for a year or more, (HUD defines “homeless” is defined as “a person sleeping in a place not meant for human habitation (e.g. living on the streets for example) OR living in a homeless emergency shelter).	
2. Has had four (4) episodes of homelessness in the last three (3) years that total 12 months.	

Disabling Mental Disorder

Documentation Supporting Medically Frail Attestation (attach additional pages if necessary)	Yes / No	Diagnosis or ICD-10 Codes (Required)
Significantly interferes with the individual's ability to function independently in an appropriate and effective manner in the functional areas of (1) Vocational/Educational, (2) Social Skills, or (3) Activities of Daily Living.		
Please describe:		

Chronic Substance Use Disorder

Documentation Supporting Medically Frail Attestation (attach additional pages if necessary)	Yes / No	Diagnosis or ICD-10 Codes (Required)
Significantly interferes with the individual's ability to function independently in an appropriate and effective manner in the functional areas of (1) Vocational/Educational, (2) Social Skills, or (3) Activities of Daily Living.		
Please describe:		

Physical Disability *(ADL must be completed)*

Beneficiary Meets the Following Criteria or Has Documentation Supporting Medically Frail Attestation	Yes / No	Diagnosis or ICD-10 Codes (Required)
The beneficiary has a physical disability.		
Please describe:		

Activities of Daily Living (Required)	Dressing	Bathing	Continence	Toileting	Eating	Mobility in Home	Transferring
	☐	☐	☐	☐	☐	☐	☐

Level of Help Necessary: supervision, cueing or hands-on assistance
Mark above if help is needed to complete the task safely and helper **DOES** need to be physically present throughout the task for **each occurrence**.

Developmental or Intellectual Disability *(ADL must be completed)*

Beneficiary Meets the Following Criteria	Yes / No	Diagnosis or ICD-10 Codes (Required)
The beneficiary has an intellectual or developmental disability as defined in Title 404 NAC 2. 1) An intellectual disability (mental retardation); or 2) A severe, chronic disability other than an intellectual disability or mental illness; which: a) Is attributable to a mental or physical impairment other than a mental or physical impairment caused solely by mental illness; b) Is manifested before the age of twenty-two years; c) Is likely to continue indefinitely; and d) Results in: i) In the case of a person three years of age or older, a substantial limitation in three or more of the following areas of major life activity, as appropriate for the person's age: (1) Self-care; (2) Receptive and expressive language development and use; (3) Learning; (4) Mobility; (5) Self-direction; (6) Capacity for independent living; and (7) Economic self-sufficiency.		

Activities of Daily Living (Required)	Dressing	Bathing	Continence	Toileting	Eating	Mobility in Home	Transferring
	☐	☐	☐	☐	☐	☐	☐

Level of Help Necessary: supervision, cueing or hands-on assistance
Mark above if help is needed to complete the task safely and helper **DOES** need to be physically present throughout the task for **each occurrence**.

Serious and Complex Medical Conditions

Beneficiary Meets One of the Following Criteria or Has Documentation Supporting Medically Frail Attestation	Yes / No	Diagnosis or ICD-10 Codes (Required)
The beneficiary is in hospice.		
The beneficiary meets criteria for hospice services.		
The beneficiary meets criteria for care in a long-term care facility or residential facility.		

Other Serious and Complex Medical Conditions Not Captured in Above Conditions

Documentation Supporting Medically Frail Attestation (attach additional pages if necessary)	Diagnosis or ICD-10 Codes (Required)
Significantly interferes with the individual's ability to function independently in an appropriate and effective manner in the functional areas of (1) Vocational/ Educational, (2) Social Skills, or (3) Activities of Daily Living.	
Please describe:	

Activities of Daily Living	Dressing	Bathing	Continence	Toileting	Eating	Mobility in Home	Transferring
	☐	☐	☐	☐	☐	☐	☐

Level of Help Necessary: supervision, cueing or hands-on assistance
Mark above if help is needed to complete the task safely and helper **DOES** need to be physically present throughout the task for **each occurrence**.

Provider Attestation

Name of Provider (Last, First, Middle Initial):	
Provider Specialty:	
Provider National Provider Identification Number:	
Telephone:	Email:
_____ Signature	_____ Date

☐ I certify that by signing this document I am a provider with diagnosing capabilities, within my Scope of Practice, and I understand that any false statement, omission, or misrepresentation may result in prosecution under state and federal laws. I agree to submit, if requested by Nebraska DHHS MLTC, any additional information in support of this attestation. I also certify that I have obtained the beneficiary's written consent to provide the Nebraska DHHS MLTC this information.