Nebraska Department of Health & Human Services
Division of Behavorial Health

Eligibility Worksheet for NBHS Funded Services

An initial Eligibility Worksheet must be completed at admission or as soon as possible after admission and must be completed annually thereafter. You may not bill the Region or DHHS for any services for this consumer until Financial Eligility has been established. The worksheet does not need to be completed for services listed on the Emergency Access Services Fee Schedule.

Consumer Name: _____

Is the consumer covered by insurance? (must check one) Yes _____ No _____

Will filing the insurance pose a risk to the consumer? (Domestic Violence, child abuse or other danger occurring) Yes____ No ____

Taxable Monthly Income _____

Annual Income _____ (Can be computed by dividing annual income by 12)

Less Monthly Total Allowable Liabiilities:

Housing : Monthly rent/lease/ mortgage amount, not to exceed **$744** per month (Limited to the home or apartment the consumer currently occupies) _____

Utilities: For the house/apartment reflected above, if the utilities are not included in rent/lease amount:
Monthly utilities, not to exeed **$615** per month _____
OR
For the house/apartment reflected above, if only a portion of utilities are included in rent/lease amount:
Monthly utilities, not to exeed **$321** per month _____

(Utilities refers to heating & cooking fuel, air conditioning, septic tank, water, sewage, trash & basic telephone only)

Transportation: Car payment and average gasoline cost or cost of public transportation, not to exceed $340 per month _____

Daycare: (if paying a 3rd Party) $362 for each child any age (Number of children ____ x $362) _____

Total Allowable Liabilities: $ -

Adjusted Monthly Income to be used to determine Eligibility for NBHS funded services: **$ -**
(Taxable Monthly Income less Monthly Total Allowable Liabilities)

Total Number of family members dependent on taxable income: _____
(consumer + spouse (if applicable) + # children (if applicable))

By signing this form, I am verifying the above amounts are correct to the best of my knowledge.

_____
Consumer signature Date

Note: You may be asked to supply documents for verification of income and liabilities claimed.

_____
Staff Person Date

For Agency Use Only:

20% of Adjusted Monthly Income = $ -
(20% is reference for maximum monthly Hardship Copay Only)

Consumer is eligible for Hardship Fee Schedule due to:

_____ SPMI
_____ SED
_____ Medical Bills or Medical Debt in excess of 10% of the taxable annual income
(Taxable Monthly Income x 12 x 10%)

As of Febuary 11th, 2026 for use in SFY27