NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

REFERRAL FORM

- ☐ Medically Handicapped Children's Program
- ☐ Disabled Children's Program (DCP)
- ☐ Genetically Handicapped Persons Program

RETURN FORM TO:
DHHS.MHCPReferrals@nebraska.gov

All fields marked with * are required. Please attach a signed release with referral.			Referral Date*
PATIENT INFORMATION			
Patient Name*	Patient Date of Birth*	Gender ☐ M ☐ F	Patient SSN*
Parent/Guardian Name*	Phone* ☐ Home ☐ Cell	Email	
Address*	City*		Zip*
MEDICAL DIAGNOSIS			
Medical Diagnosis*(Enter "DCP" for Disabled Children's Program referral).			
Has patient been hospitalized for this problem? ☐ Yes ☐ No	Hospital	Admission Date	Discharge Date
Treating Physician Name		Treating Physician Name	
Address		Address	
City/State/Zip		City/State/Zip	
Phone		Phone	
INSURANCE INFORMATION Is patient covered by: ☐ Insurance ☐ Medicaid			
Insurance Company and Policy Number			
Medicaid Plan and Policy Number			
Additional Information:			
Referral made by*		Comments:	
Facility (may use n/a)*			
Address			
Phone*			
Email*			