

Homestead Application for Redetermination

This form is used to file a request for the Department of Revenue to review an applicant's homestead exemption percentage.

County Name

FORM

458RQ

Name and Mailing Address of Homestead Applicant		Homestead Application Year Requested for Redetermination
Name of Applicant		
Phone Number		
Applicant Identification Number	Email Address	

Reasons for requested homestead exemption percentage change (**Required**) (Check all that apply)

☐ Reported Household Income

Line of 458/Income Statement that is incorrect: _____

Correct Amount: \$ _____

Reason for Correction: _____

Line of 458/Income Statement that is incorrect: _____

Correct Amount: \$ _____

Reason for Correction: _____

☐ I have completed the medical expense worksheet below and listed the total amount including expenses from the original filing. (required)

☐ Yes

☐ No

☐ Other

Please Explain: _____

Medical Expenses Worksheet:

A. Insurance Premiums

Medicare Part B (Medical Ins.)* _____

Medicare Part D (Drug Coverage) _____

Long Term Care Insurance _____

Cancer Insurance _____

Other health insurance premiums _____

B. Out of Pocked Medical Expenses Paid

Physicians _____

Hospital/Licensed nursing care facilities _____

Dental _____

Chiropractors _____

Prescription Drugs _____

Vision (Exams, glasses, contacts) _____

Hearing Aids _____

Durable Medical Equipment (DME) _____

(Includes oxygen equipment, wheelchairs, cane, walker, blood testing strips for diabetics, etc.)

C. Medical Travel

If you traveled outside of your community for medical services, you may deduct travel expenses.

_____ Miles at \$0._____ ** cents/mile = _____

Applicable Meals and Lodging while traveling _____ to be placed on Form 458 Schedule I. For Income Tax filers, Part I line 6a and non-filers of Income Tax Part II line 10a.

Total Medical Expenses (Parts A - C)

* Do not include: Medicare Part A deductions withheld from wages; self-employed health insurance that reduced total income; the medical payments portion of a car insurance policy; an accident or health insurance policy where the benefits do not specifically cover medical care; life insurance or income protection policies; employer-sponsored health insurance plans; and flexible spending accounts. These are not deductible medical insurance premiums

****Per mile reimbursement rates for the following years are as follows: 2021: \$0.16; 2022: \$0.22; 2023: \$0.22; 2024: \$0.21; 2025: \$0.21; 2026: \$0.205**

**sign
here** ▶

Signature of Homestead Exemption Applicant or Their Representative (**required**)

Date

Instructions

Where to File. This form is required to be filed with Property Assessment Division of the Department of Revenue (DOR) either through U.S. mail or by email to pat.homestead@nebraska.gov. Completed and signed forms can be mailed to:

Property Assessment Division
Attn: Homestead Exemption
PO Box 98919
Lincoln, NE 68509-8919

Who Can File. A homestead exemption applicant can file this form to request a review of their homestead exemption initial determination percentage or adjustment made by DOR. If the applicant is unable to file the this form, their authorized representative may file. Authorization to file this request on behalf of the applicant, such as a Power of Attorney, must be provided.

Request for Redetermination Filing. This form must be filed with the DOR within 30 days of receiving notification from the DOR. All supporting income and medical expense documentation must be attached to this form. Please do NOT include medical records as documentation.