Department of Health & Human Services
DHHS
NEBRASKA

Nebraska Department of Health and Human Services
BILLING DOCUMENT

Check One:
☐ Disabled Persons and Family Support Program
☑ Lifespan Respite Subsidy Program

Office Use Only
CFS-22 ID #:

Client Name:	Client ID #:	Client Phone #:
Jane Care Receiver	Required	(000) 000-0000
Parent/Legal Guardian/Conservator/Authorized Representative: (One name only)	**Client Email Address:**	
Name Provided on Program Application	email@provider.com	
Client Mailing Address: ☐ Check if the address has changed since last payment made	**City:**	**State:** / **Zip:**
112 Mail Street	My Town	NE / 00000-0000

Provider (Name of person providing the service)	Provider Email Address:	
Rhonda Respite	email@provider.com	
Provider Mailing Address: ☐ Check if the address has changed since last payment made	**City:**	**State:** / **Zip:**
P.O. Box 000	My Town	NE / 00000-0000

Payee: (Name of person to be paid)	Payee ID#: (# listed on check stub or EFT Notice)	If NEW payee, a Social Security # or a Federal Tax ID# is required:
Family and Provider Decision	Required	Only Complete if First Time Payee

Person to be paid is the: (check one)
☐ Provider ☐ Client ☐ Parent ☐ Legal Guardian ☐ Conservator ☐ Authorized Representative

INSTRUCTIONS: Submit one Billing Document per month for each provider.
Bills must be submitted within 60 days of the date of service.

AUTHORIZED SERVICE PERFORMED List below one of the following services: Respite, Personal Care, Housekeeping, Mileage (for medical care only), Incontinence/Medical Supplies	**DATES** List date of service separately (Include month, day, year)	**TOTAL NUMBER OF:** List the number of hours, days, miles, or meals for each service (Specify hours, days or miles after each number)	**COST** List the amount charged per hour, day or mile	**TOTAL AMOUNT**
Respite	02-01-2016	4 hours	$10.00	$40.00
	02-06-2016	3.5 hours	$10.00	$35.00
	02-21-2016	5 hours	$10.00	$50.00
		TOTAL BILLED		$125.00

The Client/Parent/Guardian/Conservator/Authorized Representative must verify that this billing is accurate.
For Businesses, a W-9 form will be required if you are a new provider, have an address change or a name change.
Anyone who files a false claim may be prosecuted for Fraud.

Provider Signature:	Provider Phone #	Date: (on/before client signature)
Required	Required	Required
Adult Client/Parent/Legal Guardian/Conservator/Authorized Representative's Signature		**Date: (on/after last date of service)**
Required		Required

Billing documents will be returned if the provider signs and dates after the client/authorized representative.

Submit completed and signed billing document to:
DHHS.CFS22@nebraska.gov OR Department of Health & Human Services
Division of Children & Family Services, Economic Assistance
CFS-22 Payment Reviewer
P.O. Box 95026
Lincoln, NE 68509-5026

Distribution: WHITE - DHHS Central Office; YELLOW - Payee