

**Nebraska Department of Health and Human Services
Form CFS-22 BILLING DOCUMENT INSTRUCTIONS
Lifespan Respite Subsidy Program
Revised 03/2016**

See attached sample Billing Document CFS-22 for section detail (Jane Care Receiver).

- 1) Check the box for **Lifespan Respite Subsidy Program**.
- 2) Complete the **Client name, Client ID #, phone number, Parent / Legal Guardian / Conservator / or Authorized Representative name, Client email address, and mailing address** (for the person with special needs and care receiver).
- 3) Complete the **Provider name, email address, and mailing address** (the person providing the respite services).
 - If DHHS is paying more than one Provider per Client per month, use a separate billing document for each Provider.
- 4) Complete the **Name and Payee ID #** of the person being paid. Payee ID numbers appear on DHHS check stubs and electronic fund notices.
 - If this is a new Provider OR a new person to be paid, provide the Social Security # or Federal ID # in the box provided.
 - Direct Deposit/Electronic Fund Transfer results in quicker payment by DHHS.
 - Incomplete or improperly completed forms must be returned by DHHS for correction and result in payment delay.
- 5) **Check the box** indicating who DHHS is to pay. If no box is checked, the billing document will be returned unpaid.
- 6) **Authorized Service Performed.**
 - A) Write "Respite".
 - B) Enter the **month, day, year** of each service. Only one day per line.
 - C) You must enter the **total number of** hours or days for each date of service.
 - D) Enter the **amount** charged per hour or day.
 - E) **Total amount** of each line.
 - F) **Total the bill.**

- 7) Two **signatures and dates** must be on the bottom of the form. Both the adult Client / Parent / Legal Guardian / Conservator / or Authorized Representative AND the Provider signature is required. Signatures verify the accuracy of the billing document.
- Provider phone number must be included
 - *Payment will not be made if the Provider signs and dates the form after the Client/Authorized Representative.*
 - Anyone who files a false claim may be prosecuted for Fraud.
- 8) Submit Billing Document electronically to designated Department Payment System email at dhhs.cfs22@nebraska.gov (*faster payment than US mail system*)
- OR mail to
- Department of Health & Human Services
Division of Children & Family Services, Economic Assistance
P.O. Box 95026
Lincoln, NE 68509-5026
- Use a separate billing document for each month. Submit white copy to DHHS and Payee keeps yellow copy.
 - Billing document must be submitted within **60 days of the last day of the month service was provided or the month of service will not be paid.**

Billing document(s) may be submitted on any day of the month after respite has been provided.

- First week of the month the highest volume is received.
- Payment Specialist is responsible for paying bills from several programs.
- To speed up eligible payment(s), instead of calling Program staff, submit billing questions through the designated Department Payment System email at dhhs.cfs22@nebraska.gov.
- Program policy prevents Program staff from checking on payment status unless it has been at least three (3) weeks since a billing document was submitted.

Questions: contact Linda Lehde, Lifespan Respite Subsidy Program, Social Services Worker. (402) 471-9188 or (844) 807-1197 or dhhs.respite@nebraska.gov.

Call a **Respite Network Coordinator** in your area at **1-866-RESPITE (1-866-737-7483)** to discuss respite resource needs or to become a Nebraska Lifespan Respite Network provider. You may also visit the DHHS supported website “Nebraska Resource and Referral System” at <https://nrrs.ne.gov/respitesearch/>. This free service will assist you 24/7 in finding Network screened respite providers that best fit your needs and location. You can easily search for respite resources and supportive services throughout Nebraska on the website.





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 #:

2)

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

3)

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

4)
5)

Payee: (Name of person to be paid) Family and Provider Decision	Payee ID#: (# listed on check stub or EFT Notice) Required	If NEW payee, a Social Security # or a Federal Tax ID# is required: Only Complete if First Time Payee
Person to be paid is the: (check one) <input type="checkbox"/> Provider <input type="checkbox"/> Client <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Conservator <input type="checkbox"/> Authorized Representative		

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

6)

AUTHORIZED SERVICE PERFORMED List below one of the following services:	DATES	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 Mileage (for medical care only) Personal Care Incontinence/Medical Supplies Housekeeping	List date of service separately (Include month, day, year)			
A) Respite B)	02-01-2016 C)	4 hours D)	\$10.00	\$40.00 E)
	02-06-2016	3.5 hours	\$10.00	\$35.00
	02-21-2016	5 hours	\$10.00	\$50.00
				F) \$125.00
			TOTAL BILLED	

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.

7)

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

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

8)

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
