



BILLING DOCUMENT

Lifespan Respite Subsidy Program

Office Use Only CFS-22 ID #:

Client Name:	Client ID:	Phone #:	
Parent/Legal Guardian/Authorized Representative: (circle one)		Email Address:	
Client Mailing Address: <input type="checkbox"/> Check if the address has changed since last payment		City:	State: Zip:

Provider: (person or business providing respite care)	Provider is a relative: <input type="checkbox"/> Yes <input type="checkbox"/> No	Provider Email Address:	Phone #:
Provider Mailing Address: <input type="checkbox"/> Check if the address has changed since last payment		City:	State: Zip:

A W-9 form required if you are a new provider, have an address or name change.

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:
Person to be paid is the: (check one)	<input type="checkbox"/> Provider	<input type="checkbox"/> Parent
	<input type="checkbox"/> Legal Guardian	<input type="checkbox"/> Authorized Representative
	<input type="checkbox"/> Client	
<input type="checkbox"/> Payee enrolled in EFT:	<input type="checkbox"/> Yes	<input type="checkbox"/> No

INSTRUCTIONS: Submit one Billing Document per month for each provider.

Billing document must be submitted within 60 days of the last day of the month service was provided or month of service will not be paid. All fields must be complete or will be returned and payment delayed.

AUTHORIZED SERVICE PERFORMED: (check one)		<input type="checkbox"/> Planned Respite	<input type="checkbox"/> Banking	<input type="checkbox"/> Exceptional Circumstances Funding	
BILLING MONTH	DAY (One day per line)	YEAR	List the number of hours after each date of service:	Amt charged per hour or day:	Total Amount per line:
TOTAL BILLED:					

More dates for current month on back (check to prevent extra billing document getting separated).

*I hereby certify that the above hours/dates are correct. I understand fraudulent claims may result in prosecution.

Provider Signature:	Date: (on/before client/authorized representative signature)
Adult Client/Parent/Legal Guardian/Authorized Representative's Signature: (circle one)	Date: (on/after last date of service)

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

Submit completed and signed billing document to: DHHS.CFS22@nebraska.gov (Recommended for faster payment)	OR DEPARTMENT OF HEALTH & HUMAN SERVICES Division of Children & Family Services, Economic Assistance Lifespan Respite Subsidy Program P.O. Box 98933 Lincoln, NE 68509-8933
---	--