Nebraska Family Caregiver Support
LIFESPAN RESPITE NETWORK
1-866-737-7483

Department of Health and Human Services

BILLING DOCUMENT

Disabled Persons and Family Support Program (DPFS)

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

Office Use Only
CFS-22-B ID #:

Client Name:	Client ID:	Phone #:
Parent/Legal Guardian/Authorized Representative: (circle one)	Email Address:	
Client Mailing Address: ☐ **Check if the address has changed since last payment**	City:	State: / Zip:

Provider: (person or business providing respite care)	Provider is a relative: ☐ Yes ☐ No	Provider Email Address:	Phone #:
Provider Mailing Address: ☐ **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)	☐ Provider	☐ Parent	☐ Legal Guardian	☐ Authorized Representative	☐ Client
☐ Payee enrolled in EFT:	☐ Yes	☐ 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) ☐ Planned Respite ☐ Banking ☐ Exceptional Circumstances Funding

BILLING MONTH	DAY (One day per line)	YEAR	List the number of hours after each date of serice:	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

OR

(Recommended for faster payment)

DEPARTMENT OF HEALTH & HUMAN SERVICES
Division of Children & Family Services, Economic Assistance
Disabled Persons & Family Support Program
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Distribution: WHITE - DHHS Central Office; YELLOW - Payee