

BILLING DOCUMENT

Disabled Persons and Family Support Program

Office Use Only CFS-22 ID #:

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

Provider: (Name of person providing the service)	Provider Email Address:		
Provider Mailing Address: (<input type="checkbox"/> Check if the address has changed since last payment made)	City:	State:	Zip:

Payee: (Name of person to be paid)	Payee ID#: (# listed on last check or EFT Notice)	If NEW payee, a Social Security# or a Federal Tax ID# is required:
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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 last day of the month service was provided. Providers of personal care, housekeeping, or nonfamilial medical mileage must undergo background checks to be authorized for payment.

AUTHORIZED SERVICE PERFORMED: List below one of the following services: Personal Care Mileage (for med care) Housekeeping Adaptive Equipment Medical Supplies Vehicle Modification Transportation Med / Therapeutic Services	DATES: List date of service separately (Include month, day, year)	TOTAL NUMBER OF: List the number of hours, days, or miles for each service (Specify hours, days, or miles after each number)	COST: List the amount charged per hour, day, or mile	TOTAL AMOUNT:
TOTAL BILLED:				

The Client/Parent/Guardian/Conservator/Authorized Representative must verify that this billing is accurate. A completed W-9 & ACH Enrollment Form is required for new providers or those changing their address or name. Anyone who files a false claim may be prosecuted for Fraud.

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

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

Submit completed and signed billing document to: DHHS.CFS22@nebraska.gov or
 Department of Health & Human Services
 Division of Disability and Aging
 P.O. Box 98933
 Lincoln, NE 68509-5026

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

- 1) 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).
- 2) Complete the **Provider name, email address, and mailing address** (the person providing the DPFS services).
 - o If DHHS is paying more than one Provider per Client per month, use a separate billing document for each Provider.
- 3) Complete the **Name and Payee ID #** of the person being paid. Payee ID numbers appear on DHHS check stubs and electronic fund notices.
 - o If this is a new Provider OR a new person to be paid, provide the Social Security # or Federal ID # in the box provided.
 - o Direct Deposit/Electronic Fund Transfer results in quicker payment by DHHS.
 - o Incomplete or improperly completed forms must be returned by DHHS for correction and result in payment delay.
- 4) Check the box indicating who DHHS is to pay. If no box is checked, the billing document will be returned unpaid.
- 5) Authorized Service Performed.
 - A) **Service performed.** Write the name of the authorized service(s) performed.
 - o Service(s) must match DPFS Client Approval Letter.
 - B) Enter the **month, day, year** of each service provided. Only one day per line.
 - o Attach an extra sheet if needed. Be sure to include Client Name and ID on extra sheet.
 - C) You must enter the **total number of hours or days** for each date of service.
 - D) Enter the **amount charged per hour, day or mile.**
 - o Mileage payment requires a completed DPFS Medical Mileage Reimbursement Form provided at the time service was authorized.
 - E) **Total amount** of each line.
 - F) **Total the bill.**
- 6) 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.
 - o Provider phone number must be included
 - o **Payment will not be made if the Provider signs and dates the form after the Client / Authorized Representative.**
 - o Anyone who files a false claim may be prosecuted for Fraud.

7) Submit Billing Document electronically to designated Department Payment System email at dhhs.cfs22@nebraska.gov (*faster payment than US mail system*)

OR mail to

Disabled Person's & Family Support Program

P.O. Box 98933 Lincoln, NE 68509-5026

- o Use a separate billing document for each month. Submit to DHHS.
- o Recipients or providers must submit billing documents, and receipts if required, within 60 calendar days of the last day of the month service was provided or the billing document will not be paid.

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

- o First week of the month the highest volume is received.
- o Payment Reviewer is responsible for paying bills from several programs.
- o 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.
- o 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, please contact: DPFS Program, Social Services Worker at (402) 471-9188 or (844) 807-1197 or dhhs.dpfs@nebraska.gov.

BILLING DOCUMENT

Disabled Persons and Family Support Program

Office Use Only CFS-22 ID #:

Client Name: Jane Care Receiver	Client ID #: Required	Client Phone #: (000) 000-0000	
1) 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

2) Provider: (Name of person providing the service) Rhonda Caregiver	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

3) Payee: (Name of person to be paid) Client and Provider Decision	Payee ID#: (# listed on last check or EFT Notice) Required	If NEW payee, a Social Security# or a Federal Tax ID# is required: Only Complete if First Time Payee
4) Person to be paid is the: (check one) <input checked="" 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		

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5) AUTHORIZED SERVICE PERFORMED: List below one of the following services: Personal Care Mileage (for med care) Housekeeping Adaptive Equipment Medical Supplies Vehicle Modification Transportation Med / Therapeutic Services	DATES: List date of service separately (Include month, day, year)	TOTAL NUMBER OF: List the number of hours, days, or miles for each service (Specify hours, days, or miles after each number)	COST: List the amount charged per hour, day, or mile	TOTAL AMOUNT:
A)	B)	C)	D)	E)
Personal Care	02-01-2021	4 hours	\$10	\$40
	02-04-2021	3.5 hours	\$10	\$35
	02-08-2021	4 hours	\$10	\$40
Housekeeping	02-21-2021	1.5 hours	\$10	\$15
Office Use Only. Authorized by:	Office Use Only. Authorized Date:	F) TOTAL BILLED:		\$130

The Client/Parent/Guardian/Conservator/Authorized Representative must verify that this billing is accurate. A completed W-9 & ACH Enrollment Form is required for new providers or those changing their address or name. Anyone who files a false claim may be prosecuted for Fraud.

6) 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 client/authorized representative signs and dates before the provider.

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