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

Nebraska Department of Health and Human Services

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: (☐ **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: (☐ **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:
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.

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. **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)
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.DPFS@nebraska.gov or
Department of Health & Human Services
Division of Children & Family Services, Economic Assistance SSW
P.O. Box 98933
Lincoln, NE 68509-5026

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CFS-22 BILLING DOCUMENT INSTRUCTIONS
Disabled Persons and Family Support (DPFS) Program

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
Jan Drewel, SSW
Disabled Person's & Family Support Program
P.O. Box 98933 Lincoln, NE 68509-5026

- Use a separate billing document for each month. Submit to DHHS.
- 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.

- First week of the month the highest volume is received.
- Payment Reviewer 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, please contact: Jan Drewel, DPFS Program, Social Services Worker at (402) 471-9188 or (844) 807-1197 or dhhs.dpfs@nebraska.gov.

If interested in becoming a provider within the Lifespan Respite Network, please call a Respite Network Coordinator in your area at **1-866-RESPITE (1-866-737-7483)** to become a Nebraska Lifespan Respite Network provider. You may also visit the DHHS supported website "Nebraska Resource and Referral System" at www.respite.ne.gov or https://nrrs.ne.gov/respitesearch. You can easily search for respite or DPFS provider resources and supportive services throughout Nebraska on the website.

NEBRASKA RESPITE NETWORK
1-866-RESPITE
(1-866-737-7483)

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Nebraska Department of Health and Human Services

BILLING DOCUMENT

Disabled Persons and Family Support Program

Office Use Only CFS-22 ID #:

1)

Client Name:	Client ID #:	Client Phone #:		
Jane Care Receiver	Required	(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: (☐ **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)	Provider Email Address:		
Rhonda Caregiver	email@provider.com		
Provider Mailing Address: (☐ **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)	Payee ID#: (# listed on last check or EFT Notice)	If NEW payee, a Social Security# or a Federal Tax ID# is required:
Client and Provider Decision	Required	Only Complete if First Time Payee

4)

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.

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 **A)**	**DATES:** List date of service separately (Include month, day, year) **B)**	**TOTAL NUMBER OF:** List the number of hours, days, or miles for each service (Specify hours, days, or miles after each number) **C)**	**COST:** List the amount charged per hour, day, or mile **D)**	**TOTAL AMOUNT:** **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. **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.**

6)

Provider Signature:	Provider Phone #:	Date: (on/before client signature)
Required	Required	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 provider signs and dates before the client/authorized representative.

7)

Submit completed and signed billing document to: DHHS.DPFS@nebraska.gov or
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Division of Children & Family Services, Economic Assistance SSW
P.O. Box 98933
Lincoln, NE 68509-5026