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

Nebraska Department of Health and Human Services

Nebraska State Ward Education Program Billing

1. SCHOOL SYSTEM INFORMATION		
School Name:	School District:	
City:	County:	Fed Tax ID Number:

2. INFORMATION ON YOUTH BEING BILLED FOR	
Name:	Birthdate:

Ward Status: (check one and attach verification of status)

☐ Ward if HHS or HHS-OJS

☐ Ward of_____ Probation Officer_____

(Name of Court) (Officer's Name)

Child Living Situation: (check one)

☐ Emergency Shelter ☐ Group Home ☐ Residential Treatment Center or Treatment Group Home

Name of Prior Educational Provider:

Child's School District at Time of Placement:

School District Parent(s) Currently Reside in:

Billing Dates - From:	Billing Dates - To:

Youth enrolled in (check all that apply)

☐ Regular Education ☐ Special Education ☐ Attach copy of SPED Verification ☐ Attendance Sheet

3. REGULAR EDUCATION

a. Annual Cost Per Pupil ☐ Elem ☐ Sec $_____

b. Number of School Days Scheduled in Year _____

c. Per pupil daily cost $_____ (a / b)

d. Percentage of Time Youth in Regular Education _____

e. Proportionate Per Pupil Daily Reimbursable Cost $_____ (c x d)

f. Number of Days Youth Specific in this Program _____

g. Regular Education Costs to be Billed $_____ (e x f)

4. SPECIAL EDUCATION

a. Nebraska Department of Education (NDE)
Approved Daily/Hourly Rate for Special Education $_____

b. Percentage of Time Youth in Special Education _____

c. Proportionate Daily Special Education Costs $_____ (a x b)

d. Number of Days/Hours Specific Youth in the Program _____

e. Special Education Costs to be Billed $_____ (c x d)

5. TRANSPORTATION FOR SPECIAL EDUCATION SERVICES

a. Period Transportation Provided: From_____ To_____
b. Units of Service Used: Miles_____ Trip_____
c. Units or # of Day(s) of Transportation Provided to Specific Youth _____
d. Unit costs approved by Nebraska Department of Education $_____
e. Total Transportation Costs Billed $_____ (b x c x d)
☐ Travel Log

6. SPECIAL SERVICES (i.e., speech/language, PT, OT, teacher's aid, initial evaluation)

a. Medicaid Billed ☐ Yes ☐ No
b. Category of Service_____
c. Name of Service Provider_____
d. Period of Service: From_____ To_____
e. Units of Service Used: Day_____ Hour_____
f. Units of Service Provided _____
g. Unit Cost Approved by State (HHS or NDE) $_____
h. Total Special Services Billed $_____ (f x g)

7. TOTAL BILLED

a. Total Cost of Services Billed $_____ (3g + 4e + 5e + 6h)