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

Nebraska Department of Health and Human Services

BILLING DOCUMENT
Lifespan Respite Subsidy Program

Office Use Only CFS-22-A ID #:

Client Name:	Client ID:	Phone #:
Joey Doe	00000	308-345-4990
Name of Authorized Representative (Primary Family Caregiver):	**Client Email Address:**	
Jane Doe	Joedoe43@nomail.com	
Client Mailing Address: ☐ Check if the address has changed since last payment	**City:**	**State:** / **Zip:**
PO Box 000	McCook	NE / 69001

Provider: (person, business or organization providing respite care)	Provider Email Address:	Phone #:
Betty B. There	bettywillbethere@nomail.com	000-0000
Provider Mailing Address: ☐ Check if the address has changed since last payment	**City:**	**State:** / **Zip:**
1234 My Street	McCook	NE / 69001

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:
Betty B. There		000-00-0000 (1st time)

Person to be paid is the: (check one) ☒ Provider ☐ Parent ☐ Legal Guardian ☐ Authorized Representative ☐ Client

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

Billing document must be submitted for any given month within 60 days of the date when the service is provided or the service will not be paid. All fields must be complete or will be returned and payment delayed.

BILLING MONTH/YEAR	DAY (One day per line)	List the number of hours after each date of service:	Amount charged per hour or day:	Total Amount per line:
Jan 2023	1st	2 1/2	10.00/hr	25.00
Jan 2023	2nd	2 1/2	10.00/hr	25.00
Jan 2023	8th	2.5	10.00/hr	25.00
Jan 2023	9th	2.5	10.00/hr	25.00
Jan 2023	15th	2.5	10.00/hr	25.00

☐ **Check if Exceptional Circumstances Funding included.** **TOTAL BILLED:** $125.00

☐ **Check if adding more dates on separate sheet.**

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

Provider Signature:	Provider is a relative:	Date: (on/before client/authorized representative signature)
Betty B. There	☐ Yes ☒ No	Jan 30, 2023
Authorized Representative Signature:		**Date:** (on/after last date of service)
Jane Doe		Jan 30, 2023 (same date)

Billing document must be signed on or after the last date of service by both the provider and authorized representative. The billing document will be returned if the provider signs and dates after the client/authorized representative.

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