

Department of Health and Human Services
BILLING DOCUMENT
 Lifespan Respite Subsidy Program

Office Use Only CFS-22-A ID #:

Client Name:	Client ID:	Phone #:	
Name of Authorized Representative (Primary Family Caregiver):		Client Email Address:	
Client Mailing Address: <input type="checkbox"/> Check if the address has changed since last payment	City:	State:	Zip:

Provider: (person, business or organization providing respite care)	Provider Email Address:	Phone #:	
Provider Mailing Address: <input type="checkbox"/> Check if the address has changed since last payment	City:	State:	Zip:

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) <input type="checkbox"/> Provider <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Authorized Representative <input type="checkbox"/> Client		

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.

BILLING MONTH/YEAR	DAY (One day per line)	List the number of hours after each date of service:	Amt charged per hour or day:	Total Amount per line:

- Check if Exceptional Circumstances Funding included.
- Check if adding more dates on separate sheet.

TOTAL BILLED:

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*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: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date: (on/before client/authorized representative signature)
Authorized Representative Signature:		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 (Recommended for faster payment)	OR	DEPARTMENT OF HEALTH & HUMAN SERVICES Lifespan Respite Subsidy Program P.O. Box 98933 Lincoln, NE 68509-8933
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Lifespan Respite Subsidy Program

BILLING DOCUMENT (Form CFS-22-A) INSTRUCTIONS

Please save to use as a reference. A sample billing document is also provided for you to keep as a reference. Revised 10/2018

1. **Submit the completed and signed Lifespan Respite Subsidy billing document electronically** to dhhs.cfs22@nebraska.gov. This method will provide the fastest turnaround time. Payment takes longer but you may mail to: DHHS, Lifespan Respite Subsidy Program, P.O. Box 98933, Lincoln, NE 68509-8933.
2. Please **complete all fields**. Incomplete forms will be returned for corrections which slows the payment to the payee. If you are unsure how complete any part of the billing document, contact your local Respite Coordinator.
3. You are welcome to send the form to your local Respite Coordinator for review before submitting it to Lincoln.

Contact Your Local Coordinator to Learn More:

Western Area

308-432-8190

respite@wchr.net

Southwest Area

308-345-4990

respite@swhealth.ne.gov

Central Area

308-745-0780 ext. 139

respite@centralnebraskacap.com

Northern Area

308-745-0780 ext. 145

respite@centralnebraskacap.com

Southeast

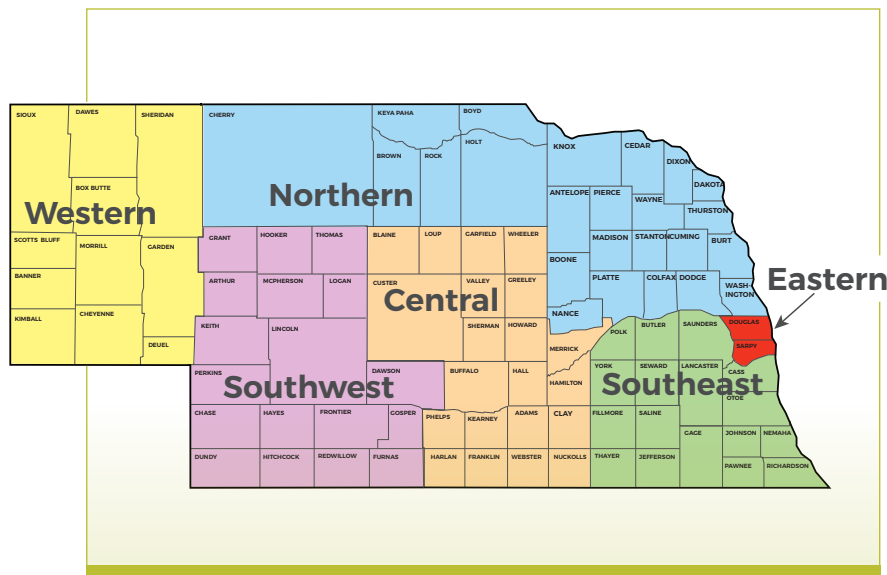
402-300-8448

southeastrespite@unmc.edu

Eastern

402-559-5732

eastrespite@unmc.edu



4. **Client Name** – The client is the person with the special need.
5. **Client ID** – The Client ID was sent with the initial (and renewal) Lifespan Respite Subsidy approval notice. Call your Respite Coordinator if needed.
6. **Name of Authorized Representative** – This is the primary family caregiver (Parent, Spouse, Grandparent, Adult Child, or Legal Guardian). Typically the primary family caregiver.
7. **Client Email (or primary family caregiver/authorized representative)** – The quickest way for DHHS or Respite Coordinator to let you something needs corrected on your billing document is by email. Watch for email from dhhs.cfs22@nebraska.gov. This is an official DHHS email address. You may also provide permission for DHHS or Respite Coordinator to contact you by text message.
8. **Client Mailing Address** – Be sure to put the full mailing address each time on every respite billing document. If address has changed, mark the box on the billing document. Remember, respite payment through direct deposit is the fastest. Talk to Respite Coordinator if you need help setting it up.
9. **Provider** – This is the person or organization providing care for your family member while you use respite.
10. **Provider Email Address** – If provider has an email address, it is important to list it here. If they do not have one, DHHS and Respite Coordinator will communicate by US Postal Service (mail). Please watch for email from dhhs.cfs22@nebraska.gov. This is an official DHHS email address. Provider may also provide permission for DHHS or Respite Coordinator to contact you by text message.
11. **Provider Mailing Address** – Be sure to put provider's full mailing address each time on every respite billing document. If address has changed, mark the box on the billing document. Remember, respite payment through direct deposit is the fastest. Talk to Respite Coordinator if you need help setting it up.
12. **Payee** – Name of person to be paid. Typically this is the respite provider.

Who Provides Respite

There is some flexibility in finding providers. Your local Respite Coordinator can assist you with finding a provider in your area. You may be able to use family members, friends or neighbors as paid providers. Depending upon funding source, other possibilities include: organizations, camps, a trusted agency, a local volunteer-led organization or group, volunteer-led school-based program, equine program, faith-based or other approved activities. While your loved one is attending an activity, you are getting a break—and that's what respite is all about!

You can locate screened respite providers at: nrrs.ne.gov/respite ▶ Click on: **"Find a Provider"**