

**INSTRUCTIONS FOR COMPLETING CONSOLIDATED SUPPORTS and SERVICES (CSS)  
BILLING FORM – NEW PORTAL**

**This form should only be used for CSS New Portal services that have been provided to individuals who are NOT enrolled in OPWDD’s Home and Community Based Services (HCBS) Waiver and are receiving services comparable to Medicaid Services. Multiple billing forms can be attached to ONE Standard Voucher (AC92) or Claim For Payment (AC3253S) but only if the billing forms are all for CSS New Portal services.**

**Submit vouchers for payment no earlier than the first day of the month following service delivery.**

AGENCY NAME: Enter your full Agency name

FEDERAL EMPLOYER ID#: Enter your Agency’s 9 digit federal employer ID number

VENDOR ID#: Enter your Agency’s 10 digit Statewide Financial System (SFS) Vendor ID number.

DDSO: Enter the name of the DDSO that is the contact for your Agency

AGENCY CONTACT PERSON: Enter the name of the person at your Agency who can be contacted to resolve any problems or questions regarding the billing form.

PHONE#: Enter a phone number, including area code and any extension, at which the contact person can be reached.

MONTH / YEAR OF SERVICE: Enter the month AND year in which the service(s) that are being billed for were provided. Please note that initial claims submitted 10/01/13 or after for services more than 3 months past the service month must be accompanied by a letter explaining the late billing. OPWDD will only pay the late submissions if the reason why submitted late was beyond provider’s control

INDIVIDUAL NAME: Enter the name of the person receiving the service during the month. The name should be entered Last Name, First Name and in alphabetical order

TABS ID: Enter the TABS (Tracking & Billing System) ID number for the participant. If unknown your DDSO contact will be able to supply you with this number

# ¼ Hr. UNITS: Enter the total number of ¼ hour units of service the participant received during the month (i.e. Participant received 4 hours of CSS New Portal, the field “# ¼ Hr. UNITS” would then show 16 units)

FEE: Enter the Fee per unit that was provided to your Agency by your DDSO contact

AMOUNT PAYABLE: Enter the total amount that should be paid to your Agency for services provided to the participant during the month of service. The amount payable is the number of ¼ Hr. Units multiplied by the Fee.

PAYEE SIGNATURE: The signature of your Executive Director or designee

TITLE: The title of the person signing the form

DATE: The date the Billing form was completed

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ATTACH FORM(S) TO A COMPLETED STANDARD VOUCHER (AC92) OR CLAIM FOR PAYMENT (AC3253S) AND MAIL TO: NYS OPWDD

BUREAU OF CENTRAL OPERATIONS  
PAYMENT PROCESSING UNIT – 4<sup>TH</sup> FL.  
44 HOLLAND AVENUE  
ALBANY, NEW YORK 12229