

INSTRUCTIONS FOR COMPLETING FISCAL INTERMEDIARY (FI) BILLING FORM For Self Direction
provided on or after 10/01/14

This form should be completed by the FI for 100% New York State Funded Items provided on or after 10/01/14

Use one form per service month – multiple services provided to an individual during a service month may be claimed on the same billing form. Multiple billing forms can be attached to ONE standard voucher (AC92) or Claim for Payment (AC3253S) for each billing

AGENCY NAME: Enter your full Agency name

FEDERAL EMPLOYER ID#: Enter your Agency's nine digit federal employer ID number

SFS 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 may 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 late submissions if the reason why submitted late was beyond provider's control.

INDIVIDUAL NAME: Enter the name of the individual 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.

SERVICE INDICATOR CODE: Enter the appropriate Service Indicator: **BSSD** (Budgeted State Service Dollars), **VL** (Vehicle Lease), **MES** (State Funding to Maintain Existing Services with IDGS), **OPRA** (State Funding for Amount over PRA)
OTHER (OPWDD will define at a later date)

UNITS: Enter the total number of Units corresponding to the total to be reimbursed by taking the total expenditure and dividing by \$10.00. If result is a whole number, enter that number as the Units. If result has decimal, enter only the whole number as the Units. Roll any unpaid expenditures to the next month. For example a total expenditure of \$112.00 divided by \$10.00 yields 11.2 Units. Enter only the 11 in the Units column. Roll the unreimbursed \$2.00 to the next month.

UNIT FEE: The fee is set at \$10.00 per unit.

AMT BILLABLE TO OPWDD: Multiply the Units by \$10.00 and enter the resulting total in the column.

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

ATTACH BILLING 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 4TH FLOOR. 44 HOLLAND AVENUE, ALBANY, NEW YORK 12229