INSTRUCTIONS FOR COMPLETING SUPPORTIVE IRA/CR RESIDENTIAL HABILITATION BILLING FORM FOR NON-MEDICAID INDIVIDUALS RECEIVING SUPPORTIVE IRA/CR RESIDENTIALHABILITATION ON OR AFTER 7/1/14

AGENCY NAME: Enter your full Agency name.

FEDERAL EMPLOYER ID#: Enter your Agency's nine 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.

SERVICE MONTH / YEAR : Enter the month AND year in which the service(s) that are being billed for were provided. **NOTE: 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.**

SUPPORTIVE IRA/CR RESIDENTIAL HABILITATION SERVICE TYPES: Please check X one SUPPORTIVE IRA/CR service type that was provided for the participants during the month. (Note: All the participant's listed on this billing form should have received the same type of SUPPPORTIVE IRA/CR service for the month. For example, all full month or all 1st half of the month, etc. Service types cannot be mixed on the form)

LOCATOR CODE: Enter the Locator Code provided by your DDSO contact

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)

PROVIDER ID#: Enter the eight digit Provider ID number that has been provided 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.

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 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 Ave., Albany, NY 12229