HOME AND COMMUNITY BASED SERVICES (HCBS) RATE AUGMENTATION BILLING WORKSHEET

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADULT AND AGING SERVICES
SFN 1789 (5-2024)

Clear Fields

HCBS Eligible Individual's Name	Month Billed
Tasks Approved *(Please number the components approved for augmentation 1, 2, 3 .....)*	

Instructions: Record the number of hours to the closest 15-minute interval and document, by number, the services provided each day services are provided.

(Example below)

Day	Hours	Tasks
24	3.45	1,2,4,6,8, etc.

Day	Hours	Tasks
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
Sub Total		Transfer to Column 2

Day	Hours	Tasks
17		
18		
19		
20		
21		
22		
23		
24		
25		
26		
27		
28		
29		
30		
31		
Sub Total from Col 1		
		Total Number of Hours of Service Provided

Qualified Service Provider PRINTED NAME	Qualified Service Provider Number
Qualified Service Provider Signature	Date Signed

Requests for payment must be received no later than 60 days from date of tasks/goods/services provided. Requests for payment must include SFN 53656, SFN 1741, SFN 1789, required supporting documentation such as an invoice, receipts and/or proof of hours.

Mail completed worksheet to: Aging Services
HCBS Rate Augmentation, 1237 W Divide Ave Suite 6
Bismarck, ND 58501

OR Email completed worksheet to: lehniemuth@nd.gov

INTERNAL OFFICE USE ONLY

Total Hours	X	Established Rate	=	Total Cost of Approved Hours	
				Total Cost of 'Other' Approved Goods and/or Services	
Billing Code				Total Approved Payment	

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