GAP-1

GAMBLERS ASSISTANCE PROGRAM

CLAIM VOUCHER

CONTRACTORS NAME		GAP PROVIDER NUMBER
DATE OF REQUEST	**MONTH SERVICES RENDERED**	**FEDERAL IDENTIFICATION NUMBER**

CALENDAR YEAR	STATE FISCAL YEAR	TYPE OF CLAIM:			
	2007		**Original**		**Amended**

REIMBURSEMENT REQUEST

TYPE OF SERVICE	TOTAL # UNITS	RATE	SUB-TOTAL
ASSESSMENT - GAMBLER		$150.00	$0.00
ASSESSMENT - SIGNIFICANT OTHER		$150.00	$0.00
CRISIS INTERVENTION		$60.00	$0.00
INDIVIDUAL (ALL CATEGORIES)		$75.00	$0.00
FAMILY THERAPY		$90.00	$0.00
GROUP THERAPY		$80.00	$0.00
OUTREACH		$55.00	$0.00
	TOTAL AMOUNT OF THIS REQUEST		$0.00

CONTRACTORS CERTIFICATION

I certify the items for which payment is claimed were furnished for State Business under the authority of the Law, and that the charges are reasonable, proper, and correct, and that no part of this Claim has already been reimbursed.

Authorized Signature Title Date

AUTHORIZATION FOR PAYMENT

Authorized Signature Date

Billings to:

Gamblers Assistance Program
Division of Behavioral Health Services
P.O. Box 98925
Lincoln, NE 68509-8925

This is a PDF document form the Nebraska HHS System Website as of 8-2006.

PROVIDER # _____

MONTH _____

GAP-2

GAMBLERS ASSISTANCE PROGRAM

***GROUP CLIENT ID DETAIL ***

DATE OF GROUP	
CLIENT ID #	**LENGTH OF GROUP**

DATE OF GROUP	
CLIENT ID #	**LENGTH OF GROUP**

DATE OF GROUP	
CLIENT ID #	**LENGTH OF GROUP**

DATE OF GROUP	
CLIENT ID #	**LENGTH OF GROUP**

DATE OF GROUP	
CLIENT ID #	**LENGTH OF GROUP**

DATE OF GROUP	
CLIENT ID #	**LENGTH OF GROUP**

PROVIDER # _____

MONTH _____

GAP-3

GAMBLERS ASSISTANCE PROGRAM

OUTREACH/PRESENTATION BILLING DETAIL

	DATE OF OUTREACH	LENGTH OF PRESENTATION	UNIT COST	TOTAL COST
1			$55.00	$0.00
2			$55.00	$0.00
3			$55.00	$0.00
4			$55.00	$0.00
5			$55.00	$0.00
6			$55.00	$0.00
7			$55.00	$0.00
8			$55.00	$0.00
9			$55.00	$0.00
10			$55.00	$0.00
11			$55.00	$0.00
12			$55.00	$0.00
13			$55.00	$0.00
14			$55.00	$0.00
15			$55.00	$0.00
			TOTAL	**$0.00**

REIMBURSEMENT RATES
OUTREACH: $55.00

PROVIDER # _____

PLAN MONTH _____

CONTRACT YEAR _____

GAP-4

GAMBLERS ASSISTANCE PROGRAM

OUTREACH PLAN

AGENCY / PROVIDER: _____

FAX: _____

# OF UNITS	ACTIVITY	PURPOSE (INCLUDE TARGET AUDIENCE)	DATE	DIVISION APPROVAL	REASON

PROVIDER # _____
MONTH _____

GAP-5

GAMBLERS ASSISTANCE PROGRAM

CONSUMER VOUCHER BILLING DETAIL

CONSUMER ID NUMBER _____

	Date	Service Type	Voucher#	# of Units	Cost
1					$0.00
2					$0.00
3					$0.00
4					$0.00
5					$0.00
				TOTAL COST	**$0.00**

CONSUMER ID NUMBER _____

	Date	Service Type	Voucher#	# of Units	Cost
1					$0.00
2					$0.00
3					$0.00
4					$0.00
5					$0.00
				TOTAL COST	**$0.00**

CONSUMER ID NUMBER _____

	Date	Service Type	Voucher#	# of Units	Cost
1					$0.00
2					$0.00
3					$0.00
4					$0.00
5					$0.00
				TOTAL COST	**$0.00**

PAGE TOTAL **$0.00**

PROVIDER # _____
MONTH _____

GAP-6

GAMBLERS ASSISTANCE PROGRAM

CRISIS INTERVENTION BILLING DETAIL

CONSUMER ID NUMBER _____

	Date (current reimburse)	Date (previous reimburse)	Service Type	# of Units	Cost
1			CRISIS		$0.00
2			CRISIS		$0.00
3			CRISIS		$0.00
				TOTAL COST	$0.00

CONSUMER ID NUMBER _____

	Date		Service Type	# of Units	Cost
1			CRISIS		$0.00
2			CRISIS		$0.00
3			CRISIS		$0.00
				TOTAL COST	$0.00

CONSUMER ID NUMBER _____

	Date		Service Type	# of Units	Cost
1			CRISIS		$0.00
2			CRISIS		$0.00
3			CRISIS		$0.00
				TOTAL COST	$0.00

CONSUMER ID NUMBER _____

	Date		Service Type	# of Units	Cost
1			CRISIS		$0.00
2			CRISIS		$0.00
3			CRISIS		$0.00
				TOTAL COST	$0.00

PAGE TOTAL $0.00