ATTACHMENT CC
FEE SCHEDULE

Providers must provide detailed fixed prices for all costs associated with the responsibilities and related services. This applies to all providers wherein the service is not contained in the State of Nevada's Medicaid Rate Schedule or an established fee schedule in the Scope of Work.

The fee schedule shall include the provider's name, service description, rate and fees associated with the service and any additional associated costs. Additional pages may be attached if necessary.

Contact Information

Provider Representative:_____

Business Name:_____

Telephone Number:_____

Email:_____

Service Description	**Rate/Fee**	
		☐hourly ☐daily ☐milestone ☐other _____
		☐hourly ☐daily ☐milestone ☐other _____
		☐hourly ☐daily ☐milestone ☐other _____
		☐hourly ☐daily ☐milestone ☐other_____
		☐hourly ☐daily ☐milestone ☐other _____
		☐hourly ☐daily ☐milestone ☐other _____
		☐hourly ☐daily ☐milestone ☐other _____

Associated Costs	
Description	**Rate/Fee**

The fee schedule is only valid upon the Administrator of Vocational Rehabilitation's approval.

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Administrator's Signature Date