

Ohio Department of Job and Family Services
PUBLICLY FUNDED CHILD CARE
REQUEST FOR OHIO ECC PAYMENT ADJUSTMENT

COUNTY REQUEST

PROVIDER REQUEST

County Department of Job and Family Services: send this form to child_care_adjustment@jfs.ohio.gov . Providers: send this form to the County Department of Job and Family Services.

SECTION I. PROVIDER AND CASE INFORMATION				
Provider Name	Provider ID Number	Authorization Number		
Caretaker First Name	Caretaker Last Name	Case Number (10 digits)		
Child First Name	Child Last Name	Child ID Number (12 digits)		
Service Week/Period (MM/DD/YYYY - MM/DD/YYYY)		Settlement Date (MM/DD/YYYY)		
SECTION II. REASON FOR REQUEST (only submit request if payment is being changed. You must use one form for each week.)				
Reason for the request (check one)				
<input type="checkbox"/> Swipe error (No new attendance) <input type="checkbox"/> Authorization change <input type="checkbox"/> Caretaker withdrew without notice (attendance record required)				
<input type="checkbox"/> Manual Claim Error (County request only)				
Describe the reason for this request				
SECTION III. ATTENDANCE DURING SERVICE WEEK/PERIOD				
Attendance (enter in and out time, including hours and minutes with AM or PM indicator)				
Enter Sunday Begin Date: _____ (MM/DD/YYYY) for the service/week period of attendance you are submitting				
Day of Week	Time in (HH:MM) check AM/PM	Time out (HH:MM) check AM/PM	Time in (HH:MM) check AM/PM	Time out (HH:MM) check AM/PM
Sunday	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM
Monday	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM
Tuesday	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM
Wednesday	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM
Thursday	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM
Friday	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM
Saturday	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM
SECTION IV. SIGNATURES (By signing below, I agree that my child was in care at this provider during the dates and times entered above)				
Caretaker Signature			Date Caretaker Signs (MM/DD/YYYY)	
Caretaker Name (please print)			Phone Number of Caretaker	
<i>(By signing below, I agree that I provided care to this child at this provider during the dates and times entered above)</i>				
Provider/Designee Signature			Date Provider/Designee Signs (MM/DD/YYYY)	
Provider/Designee Name (please print)			Phone Number of Provider/Designee	
The total payment amount is subject to payment rules and procedures required by the Ohio Department of Job and Family Services. The provider must submit this completed form to the County Department of Job and Family Services to request a payment adjustment. This form must be received or post marked no later than 7 weeks from the last day of the week of service being submitted unless otherwise determined by the ODJFS Bureau of State Hearings.				

Sunday Begin Date	Child ID Number
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SECTION V. REVISED PAYMENT INFORMATION

Age Category of Child <i>(check one)</i>	<input type="checkbox"/> infant <input type="checkbox"/> toddler <input type="checkbox"/> preschool <input type="checkbox"/> school age <input type="checkbox"/> summer school age	
Customary Rate <i>(from CP)</i>	\$	
Appendix Rate <i>(appendix to Rule 5101:2-16-41)</i>	\$	
Child Special Needs <i>(from EA)</i>	\$	
Child Special Needs Waiver <i>(from EA)</i>	\$	
Non-traditional Care	\$	
Accreditation or Star Rating <i>(from CP)</i> <input type="checkbox"/> NAEYC <input type="checkbox"/> NAFCC <input type="checkbox"/> NECPA <input type="checkbox"/> COA <input type="checkbox"/> NAC <input type="checkbox"/> ACSI <input type="checkbox"/> SUTQ Star Rated <input type="checkbox"/> SUTQ 2 Star Rated <input type="checkbox"/> SUTQ 3 Star Rated <input type="checkbox"/> SUTQ 4 Star Rated <input type="checkbox"/> SUTQ 5 Star Rated	\$	
Copayment Amount <i>(from EA)</i>	\$	
Original Payment Amount for Week \$	Revised Payment Amount for Week \$	Adjustment Amount \$ <i>Check one</i> <input type="checkbox"/> overpayment <input type="checkbox"/> underpayment

SECTION VI. IN HOME AIDE (only complete if in home aide)

Customary Rate \$	Weekly Cost of Care \$	Copayment Amount \$	Number of Children
Original Payment Amount for Week \$	Revised Payment Amount for Week \$	Adjustment Amount \$	<i>check one</i> <input type="checkbox"/> overpayment <input type="checkbox"/> underpayment

SECTION VII. COUNTY CONTACT

County	County Worker Phone Number
County Worker First Name	County Worker Last Name

SECTION VIII. FOR COUNTY USE ONLY

Check here if Adjustment is denied and list reason. Keep in County files.