Rule Summary and Fiscal Analysis (Part A)

Department of Job and Family Services
Agency Name

Division of Social Services
Division

Michael Lynch
Contact

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5101:2-16-07
Rule Number

AMENDMENT
TYPE of rule filing

Rule Title/Tag Line

County department of job and family services (CDJFS) responsibilities for the administration of publicly funded child care.

RULE SUMMARY

1. Is the rule being filed consistent with the requirements of the RC 119.032 review? **Yes**

2. Are you proposing this rule as a result of recent legislation? **No**

3. Statute prescribing the procedure in accordance with the agency is required to adopt the rule: **119.03**

4. Statute(s) authorizing agency to adopt the rule: **5104.30, 5104.34, 5104.38**

5. Statute(s) the rule, as filed, amplifies or implements: **5104.01, 5104.30, 5104.34, 5104.38**

6. State the reason(s) for proposing (i.e., why are you filing,) this rule:

This rule is being proposed for amendment as a result of a Five Year Review.

7. If the rule is an AMENDMENT, then summarize the changes and the content

of the proposed rule; If the rule type is RESCISSION, NEW or NO CHANGE, then summarize the content of the rule:

This rule contains the responsibilities of the county departments of job and family services for the administration of publicly funded child care. This rule is being amended to clarify that participating in state and federal reviews of publicly funded child care is a requirement.

8. If the rule incorporates a text or other material by reference and the agency claims the incorporation by reference is exempt from compliance with sections 121.71 to 121.74 of the Revised Code because the text or other material is **generally available** to persons who reasonably can be expected to be affected by the rule, provide an explanation of how the text or other material is generally available to those persons:

This rule incorporates one or more dated references to an ODJFS form or forms. Each cited ODJFS form is dated and is generally available to persons affected by this rule via the "Info Center" link on the ODJFS web site (http://jfs.ohio.gov//) in accordance with RC 121.75(E).

This rule incorporates one or more references to the Ohio Revised Code. This question is not applicable to any incorporation by reference to the Ohio Revised Code because such reference is exempt from compliance with RC 121.71 to 121.74 pursuant to RC 121.76(A)(1).

This rule incorporates one or more references to another rule or rules of the Ohio Administrative Code. This question is not applicable to any incorporation by reference to another OAC rule because such reference is exempt from compliance with RC 121.71 to 121.74 pursuant to RC 121.76(A)(3).

This rule incorporates one or more dated references to a federal act or acts. This question is not applicable to any dated incorporation by reference to a federal act because such reference is exempt from compliance with RC 121.71 to 121.74 in accordance with RC 121.75(C).

9. If the rule incorporates a text or other material by reference, and it was **infeasible** for the agency to file the text or other material electronically, provide an explanation of why filing the text or other material electronically was infeasible:

Not applicable.

10. If the rule is being **rescinded** and incorporates a text or other material by

reference, and it was **infeasible** for the agency to file the text or other material, provide an explanation of why filing the text or other material was infeasible:

Not Applicable.

11. If **revising** or **refiling** this rule, identify changes made from the previously filed version of this rule; if none, please state so. If applicable, indicate each specific paragraph of the rule that has been modified:

Not Applicable.

12. 119.032 Rule Review Date: **2/11/2014**

(If the rule is not exempt and you answered NO to question No. 1, provide the scheduled review date. If you answered YES to No. 1, the review date for this rule is the filing date.)

NOTE: If the rule is not exempt at the time of final filing, two dates are required: the current review date plus a date not to exceed 5 years from the effective date for Amended rules or a date not to exceed 5 years from the review date for No Change rules.

FISCAL ANALYSIS

13. Estimate the total amount by which *this proposed rule* would **increase / decrease** either **revenues / expenditures** for the agency during the current biennium (in dollars): Explain the net impact of the proposed changes to the budget of your agency/department.

This will have no impact on revenues or expenditures.

0

No impact on current budget.

14. Identify the appropriation (by line item etc.) that authorizes each expenditure necessitated by the proposed rule:

Not applicable.

15. Provide a summary of the estimated cost of compliance with the rule to all directly affected persons. When appropriate, please include the source for your information/estimated costs, e.g. industry, CFR, internal/agency:

No new costs are anticipated as a result of this rule amendment.

16. Does this rule have a fiscal effect on school districts, counties, townships, or municipal corporations? **No**

17. Does this rule deal with environmental protection or contain a component dealing with environmental protection as defined in R. C. 121.39? **No**

S.B. 2 (129th General Assembly) Questions

18. Has this rule been filed with the Common Sense Initiative Office pursuant to R.C. 121.82? **No**

19. Specific to this rule, answer the following:

A.) Does this rule require a license, permit, or any other prior authorization to engage in or operate a line of business? **No**

B.) Does this rule impose a criminal penalty, a civil penalty, or another sanction, or create a cause of action, for failure to comply with its terms? **No**

C.) Does this rule require specific expenditures or the report of information as a condition of compliance? **No**

Ohio Department of Job and Family Services

PUBLICLY FUNDED CHILD CARE
MANUAL CLAIM FOR ATTENDANCE

SECTION I. PROVIDER TO COMPLETE THIS SECTION *(please print)*

Provider Name *(as printed on Certificate or License)*	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)*

SECTION II. REASON FOR MANUAL CLAIM *(check only one reason below for which services could not be completed within the back swipe period)*

- ☐ Authorization prior to back swipe period (MCPB)
- ☐ State Hearing decision (MCSH)
- ☐ POS device not installed (MCND)
- ☐ Caretaker awaiting swipe card (MCAC)
- ☐ Caretaker withdraws without notice (MCCW)

SECTION III. ADDITIONAL INFORMATION *(include details regarding claim below)*

SECTION IV. ABSENT DAY

Enter Sunday Begin Date: _____ *(MM/DD/YYYY)* for the week of attendance you are submitting
indicate day(s) of the week the Absent Day(s) requested and the date in the format of MM/DD/YYYY

☐ Sun. _____ ☐ Mon. _____ ☐ Tues. _____ ☐ Wed. _____
☐ Thurs. _____ ☐ Fri. _____ ☐ Sat. _____

SECTION V. CARETAKER OR PROVIDER TO COMPLETE THIS SECTION *(please print)*

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	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM
Monday	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM
Tuesday	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM
Wednesday	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM
Thursday	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM
Friday	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM
Saturday	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM

SECTION VI. SIGNATURES *(by signing below, I agree that my child was in care at this provider during the dates and times entered above)*

Caretaker Signature *(not needed if caretaker withdraws without notice)*	Date Caretaker Signs *(MM/DD/YYYY)*
Caretaker Name *(please print)*	Phone Number of Caretaker

(By signing below, I agree that I provided care to this child at this provider during the dates and times entered above)

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 payment for a manual claim. This form must be received or post marked ***no later than 7 weeks from the week of service being submitted*** unless otherwise determined by the Bureau of State Hearings.

SECTION VII. FOR COUNTY USE ONLY

☐ Check here if Manual Claim is denied and list reason below

ACTION: Original

DATE: 02/11/2014 9:36 AM

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)*

☐ Swipe error ☐ Authorization change

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	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM
Monday	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM
Tuesday	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM
Wednesday	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM
Thursday	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM
Friday	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM
Saturday	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ 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

(By signing below, I agree that I provided care to this child at this provider during the dates and times entered above)

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**

SECTION V. REVISED PAYMENT INFORMATION		
Age Category of Child *(check one)*	☐ infant ☐ toddler ☐ preschool ☐ school age ☐ summer school age	
Customary Rate *(from CP)*	$	
Appendix Rate *(appendix to Rule 5101:2-16-41)*	$	
Child Special Needs *(from EA)*	$	
Child Special Needs Waiver *(from EA)*	$	
Non-traditional Care	$	
Accreditation or Star Rating *(from CP)* ☐ NAEYC ☐ NAFCC ☐ NECPA ☐ COA ☐ NAC ☐ ACSI ☐ SUTQ Star Rated ☐ SUTQ 2 Star Rated ☐ SUTQ 3 Star Rated ☐ SUTQ 4 Star Rated ☐ SUTQ 5 Star Rated	$	
Copayment Amount *(from EA)*	$	
Original Payment Amount for Week $	Revised Payment Amount for Week $	Adjustment Amount $ *Check one* ☐ overpayment ☐ 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 $ *check one* ☐ overpayment ☐ 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.