Summit County
CHILDREN SERVICES
Building Families . . . Building Futures

264 S. Arlington Street ▪ Akron, Ohio 44306-1354 ▪ Phone: (330) 379-9094 ▪ Fax: (330) 379-1901 ▪ www.summitkids.org

PASSS 2018 - 2019

Dear Adoptive Parent:

Enclosed, please find the Post Adoption Special Services Subsidy application for the new fiscal year **beginning on July 1, 2018 and ending June 30, 2019.**

The packet includes:

- PASSS Application (JFS 1050)
- Application for Additional PASSS Funding (JFS 1051)
- Applicant Financial Statement (JFS 1681)
- PASSS Health Insurance Form
- Professional Letter of Attestation
- Credential for Professional Providers/Memorandum of Understanding (JFS 1052)
- Respite Provider Information Form
- Respite Reimbursement Invoice
- Ohio Department of Job and Family Services PASSS rules & State Hearing Guidelines

You may request up to $10,000 for PASSS allowable services per adopted child each fiscal year and will be notified of your approval/denial by written letter.

PASSS fund are not guaranteed and approved funds will be reviewed on a quarterly basis. If funds are not being used, the allocated money may be returned to the state.

Please remember that the PASSS rules stipulate services will be approved at the Medicaid reimbursement rate regardless of whether a provider accepts Medicaid and/or a child is eligible for Medicaid. With the exception of respite, any services provided to your child must be administered by a licensed qualified professional as defined in the PASSS rules.

All PASSS applications must include an attestation letter that supports the need for each service as well as the completed credentials form; this includes respite care.

Please note: INCOMPLETE APPLICATION PACKETS WILL BE RETURNED.

Sincerely,

Tammy Luhring, LSW
Post-Adoption Specialist
(330)996-1005

Approved By:

Maureen Flynn, BA
Permanency Planning Supervisor

CC: Trina Danzy, MSW, LSW
Director of Placement & Permanency Planning

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PASSS CHECKLIST

In order to process your application in a timely manner, you must furnish the following documents and statements. Please submit all documents together or they may be returned.

☐ **Application for Post Adoption Special Services Subsidy (JFS 1050).** Signature required at bottom of page.

☐ **Application for Additional Post Adoption Special Services Subsidy (PASSS) Funding for Extraordinary Circumstances (JFS 1051).** ***Required only if requesting funding for out of home placement or there has been involuntary loss of employment during the SFY.***

☐ **Applicant Financial Statement (JFS Form 1681)** - Signature required at bottom of page.

☐ **Income Verification** – submit most recent income tax form showing Adjusted Gross Income.

☐ **A written statement from the adoptive parents** that clearly indicates why the requested service needed and is not within the resources of the family.

☐ **PASSS Health Insurance Form-** Signature required at bottom of page..

☐ **A copy of your private health insurance policy if applicable.** You will need to send a denial if insurance does not cover requested service(s).

☐ **Professional Attestation: To be completed by the qualified professional recommending services.**

☐ **Credentials for Providers of PASSS Funded Therapeutic Services/Memorandum of Understanding (JFS 1052). Must be completed by each licensed professional who will provide PASSS funded services to your child.**

☐ **Copy of adoption decree.**

☐ **PASSS Respite Provider Information:** To be filled out if you are applying for respite. One form for each respite provider that you intend to utilize.

***Please refer to the ODJFS Instructions for Completing Application for PASSS services included in your packet for further assistance.

SUMMIT COUNTY PASSS

2018-2019

Monthly Application Deadlines

As we accept PASSS applications each month, it is important for you to know the date by which a PASSS Coordinator must have your completed application in order to present it to the PASSS committee for approval. Here are the monthly deadlines to submit an application:

July 20, 2018	January 18, 2019
August 24, 2018	February 15, 2019
September 21, 2018	March 22, 2019
October 19, 2018	April 19, 2019
November 16, 2018	May 17, 2019
December 14, 2018	June 2019 (as needed basis)

Any questions please contact your
Summit County PASSS Coordinator
Tammy Luhring
(330)996-1005

& THANK YOU

Ohio Department of Job and Family Services

INSTRUCTIONS FOR COMPLETING JFS 01050, APPLICATION FOR POST ADOPTION SPECIAL SERVICES SUBSIDY

Note: A separate application must be completed for each child. *

SECTION I: ***Agency Information***

Name of Public Children Services Agency (PCSA): Enter the name of the PCSA where this application will be submitted.
Date of Application: Enter the month, day and year in which this application was completed and submitted to the PCSA.

SECTION II: ***Family Information***

Name of Adoptive Parent(s): Enter the first and last name(s) of the adoptive parent(s).
Adoptive Family Address and Telephone Number: Enter the adoptive family's current address (including city, state and zip code) and telephone number.
Number of Children in Home: Enter the number of adopted, biological or other (i.e. kinship/foster care) children that reside in the home.
Annual Family Income: Enter the amount of the annual family income as reported on the most current IRS 1040.

SECTION III: ***Child Information***

Name of Adoptive Child: Enter the first and last name of the adoptive child.
Date of Birth: Enter the adoptive child's date of birth.
Gender: Enter the gender of the adoptive child.
Date Adoption Finalized: Enter the month, day and year in which the child's adoption was finalized.
Type of Adoption: Check the box that applies to the type of adoption.
Briefly Describe the Treatment Needs of the Child: Briefly describe what type of treatment is being sought for the child. Per Ohio Administrative Code (OAC) 5101:2-44-13.1, in order to be eligible for PASSS funds all of the following must be met: The child has a physical or developmental handicap or mental or emotional condition that either existed before the adoption petition was filed or developed after the adoption petition was filed and can be directly attributed to factors in the child's preadoption background or medical history, or biological family's background or medical history. (If more space is needed, an additional sheet may be attached).

SECTION IV: ***Services Requested***

Therapeutic Techniques Requested As part of the application process, a JFS 01052 "Credentials for Providers of PASSS Funded Therapeutic Services and Memorandum of Understanding" must be completed and submitted at the time of application. If the individual providing therapy is not a licensed provider then PASSS funds shall not be approved.

Type of Therapy: Identify the type of therapy that is being requested for the child (psychiatric, psychological or substance abuse counseling or other).
Name of Provider: List the name of the individual that will be providing therapy to the child.
Licensing Board: List the name of the Licensing Board under which the provider is authorized to practice.
Cost of Service: Enter the cost of the service(s) requested as accurately as possible.

Other Service(s) Requested Check the box that applies to the type of service(s) requested for the child. If requesting medical and/or mental health respite, these costs may not exceed $2,400, respectively, per child per state fiscal year (SFY).

Additional Respite: The PCSA may elect, on a case by case basis, to approve an additional $2,400 for mental health and/or $2,400 for medical respite under special circumstances that the PCSA has outlined in its adoption policy.
Cost of Service: Enter the cost of the service(s) requested as accurately as possible.

Out of Home Care Requested: Complete this section if the service requested is for residential treatment, in-patient hospitalization or therapeutic foster care. Approved services for any type of residential treatment facility or therapeutic foster care must be provided by a residential facility or foster care home that is licensed by the Ohio department of job and family services (ODJFS) or the Ohio department of mental health and addiction services (ODMHAS) or a comparable agency which is recognized by a state or a similar licensing body.

Residential Treatment: List the name of the residential treatment facility and the name of the agency in which the facility is licensed by. *(Note: Educational costs shall not be included).*
In-patient Hospitalization: List the name of the facility in which the child will receive in-patient services.
Therapeutic Foster Care: List the name of the agency in which the facility providing therapeutic foster care is licensed under.
Cost of Service: Enter the cost of the service(s) requested as accurately as possible.
Total: Enter the total costs of all services requested. *(Note: The total costs of all services requested shall not exceed $10,000 per child per SFY. If a JFS 01051, Application for Additional Post Adoption Special Services (PASSS) Funding, has been completed and approved, the total costs of all services requested shall not exceed $15,000 per child per SFY).*

SECTION V: ***Resources***

Resources: Identify **all** of the community resources that have been contacted (and the dates of those contacts) to provide assistance in addressing the child's physical or developmental handicap, or mental or emotional condition. If funding has been received from a resource not listed, please identify the resource in the section marked "other." Enter the month, day and year in which the resource was contacted, if applicable. Indicate the total amount of funding received, if applicable, from each resource that has been contacted.
Total Received: Enter the total amount of funding received from all of the resources listed, if applicable.

SECTION VI: ***Affirmation***

Documentation: A copy of **all** of the documentation outlined in this section must be submitted along with the completed JFS 01050.
Adoptive Parent(s) Signature: By signing this application, you confirm that the information given in this application is accurate and you acknowledge that you are aware that you will be required to provide verification of your financial situation. (In accordance with section 2921.13 of the Ohio Revised Code, it is a misdemeanor of the first degree to knowingly falsify statements when the statement is made to secure benefits administered by a governmental agency or paid out of a public treasury).
Right to a State Hearing: This section informs you of your right to request a state hearing if you do not agree with the decision made by the agency.

Ohio Department of Job and Family Services

APPLICATION FOR POST ADOPTION SPECIAL SERVICES SUBSIDY

SECTION I: AGENCY INFORMATION

Name of Public Children Services Agency	Date of Application

SECTION II: FAMILY INFORMATION

Name of Adoptive Parent	Name of Adoptive Parent	
Home Address	City, State and Zip Code	Telephone Number ( )
Number of dependent children in home Adopted Biological Other		Annual Family Income

SECTION III: CHILD INFORMATION

Last Name of Adopted Child	First Name of Adopted Child	Date of Birth
Gender ☐ Male ☐ Female	Date Adoption Finalized	Was the child adopted by a relative? ☐ Yes ☐ No

Type of Adoption
☐ Attorney/Independent ☐ International ☐ Private Agency ☐ Public Agency

Briefly describe your child's physical/developmental handicap or mental/emotional condition **and** attach a statement from a qualified professional.

SECTION IV: SERVICES REQUESTED

THERAPEUTIC TECHNIQUE(S) REQUESTED
(Check all that apply)

Type of Therapy	Name of Provider	Licensing Board	Cost of Service(s)
☐ Psychiatric Counseling			$
☐ Psychological Counseling			$
☐ Substance Abuse Counseling			$
☐ Other *(Specify)*			$
☐ Other *(Specify)*			$

OTHER SERVICES REQUESTED

	$
☐ Occupational Therapy ☐ Physical Therapy ☐ Speech Therapy	$
Respite *(Check all that apply)* ☐ Medical **($2,400 MAXIMUM)** ☐ Mental Health **($2,400 MAXIMUM)**	$
Additional Respite *(Check all that apply)* ☐ Medical **($2,400 MAXIMUM)** ☐ Mental Health **($2,400 MAXIMUM)**	$
☐ Medical Equipment ☐ Surgery	$

OUT OF HOME CARE REQUESTED

Type of Out of Home Care	Name of Treatment Facility	Licensed By	Cost of Service(s)
☐ Residential Treatment *(EXCLUDING EDUCATIONAL COSTS)*			$
☐ In-patient Hospitalization			$
☐ Therapeutic Foster Care			$
		TOTAL COSTS OF ALL SERVICES REQUESTED	$

SECTION V: RESOURCES (Identify all resources explored, including date contacted, and indicate the amount received, if applicable).

☐ Alcohol and Drug Addiction Board	☐ Yes	☐ No	DATE	$
☐ Alcohol, Drug Addiction and Mental Health (ADAMH)	☐ Yes	☐ No	DATE	$
☐ Family and Children First Council	☐ Yes	☐ No	DATE	$
☐ Medicaid	☐ Yes	☐ No	DATE	$
☐ DODD Family Resource Program	☐ Yes	☐ No	DATE	$
☐ Prevention, Retention, Contingency Fund	☐ Yes	☐ No	DATE	$
☐ Private/Family	☐ Yes	☐ No	DATE	$
☐ Public School District	☐ Yes	☐ No	DATE	$
☐ State Adoption Subsidy	☐ Yes	☐ No	DATE	$
☐ Title IV-E Adoption Assistance	☐ Yes	☐ No	DATE	$
☐ Title XX Benefits	☐ Yes	☐ No	DATE	$
☐ Veteran's Benefits	☐ Yes	☐ No	DATE	$
☐ Other	☐ Yes	☐ No	DATE	$
			TOTAL RECEIVED	$

SECTION VI: AFFIRMATION

I have provided the Public Children Services Agency (PCSA) with a copy of <u>all</u> of the following documentation:

☐ a clear written statement of my child's special needs;

☐ an assessment and/or evaluation from a qualified professional;

☐ an estimate of the cost of service(s) that will be provided;

☐ updated financial information; and

☐ my public or private insurance policy regarding the services required, if applicable, and eligibility for services under this program.

I affirm, under penalty of perjury, that the information in this application is accurate. I understand that verification of my financial situation will be required. I understand and agree that the PCSA may contact other persons or organizations to obtain the necessary proof of eligibility and level of benefits. I understand that in some instances, I may be asked to give consent to the PCSA to make whatever contacts are necessary to determine eligibility. I consent to the release of this form and supporting documentation to the review committee established under Ohio Administrative Code rule 5101:2-44-13. I acknowledge that approval is contingent upon the availability of state funds for this program.

I understand that as a condition of continued eligibility for PASSS funds I am required to submit a copy of my child's treatment plan within 30 days of the initial visit, completed by the service provider that details the therapeutic intervention that will be provided for the period in which this application is in effect.

I understand that my application will be reviewed within twenty days after the close of each quarter during the state fiscal year (SFY) in which it was approved. If the results of this review determine that the approved funds have not been utilized, I will be notified by the PCSA, within five days of the review, of their intent to release these funds. I will have twenty days from that notification to produce any outstanding invoices for that quarter. If I do not submit the invoices to the PCSA within the twenty days, the funds will be released to the Ohio Department of Job and Family Services and I will be financially responsible for any outstanding balances in these invoices.

Signature of Adoptive Parent	Date	Signature of Adoptive Parent	Date

RIGHT TO A STATE HEARING: You have a right to a state hearing before the Ohio Department of Job and Family Services if your application is denied or if you disagree with any other actions taken on your application. For a complete explanation of your hearing rights and the hearing process, please read the JFS 04059 "Explanation of State Hearing Procedures." A copy of the JFS 04059 should be given to you along with this application form.

COMPLETION OF THIS FORM IS REQUIRED FOR THE ESTABLISHMENT OF A POST ADOPTION SPECIAL SERVICES SUBSIDY.

Ohio Department of Job and Family Services

INSTRUCTIONS FOR COMPLETING JFS 01051, APPLICATION FOR ADDITIONAL POST ADOPTION SPECIAL SERVICES SUBSIDY (PASSS) FUNDING FOR EXTRAORDINARY CIRCUMSTANCES

Note: A separate application must be completed for each child

Name of Public Children Services Agency (PCSA): Enter the name of the PCSA in which this application will be submitted. The application must be submitted to the agency located in the parent's county of residence.

Date of Application: Enter the month, day and year in which this application was completed and submitted to the PCSA.

Child's Adoptive Name: Enter the first and last name of the adoptive child.

Date of Birth: Enter the month, day and year in which the adoptive child was born.

Name of Adoptive Parent(s): Enter the first and last name of the adoptive parent(s).

Adoptive Family Address and Telephone Number: Enter the adoptive family's current street address, city, state, zip code and telephone number.

Amount of Additional PASSS Funds Requested: Enter the amount of additional PASSS funding requested. Per 5101:2-44-13.1, families may request up to an additional $5,000 per child per state fiscal year if at least one of the extraordinary circumstances exists. Select the box that reflects the extraordinary circumstance that exists. Specify what services the additional PASSS funding will be used for.

Adoptive Parent(s) Signature: By signing this application, you confirm that the information given in this application is accurate and you acknowledge that you are aware that you will be required to provide verification of your financial situation. In accordance with section 2921.13 of the Ohio Revised Code, it is a misdemeanor of the first degree to knowingly falsify statements when the statement is made to secure benefits administered by a governmental agency or paid out of a public treasury.

Right to a State Hearing: This section informs you of your right to request a state hearing if you do not agree with the decision made on your application.

For Agency Use Only: This section will be used by the PCSA director or designee to approve or deny the application.

Ohio Department of Job and Family Services

APPLICATION FOR ADDITIONAL POST ADOPTION SPECIAL SERVICES SUBSIDY (PASSS) FUNDING FOR EXTRAORDINARY CIRCUMSTANCES

Public Children Services Agency			Date of Application
Child's Name: Last	First		Date of Birth
Name of Adoptive Parent	Name of Adoptive Parent		
Address	City	State	Zip Code

I am requesting additional PASSS funding in the amount of $ for the above-mentioned child due to one of the following circumstances:

☐ Involuntary loss of employment during the State Fiscal Year (SFY) in which this application was made and the required services exceed the initial ten thousand dollars provided; or

☐ A qualified professional has recommended residential treatment, inpatient hospitalization or therapeutic foster care (a copy of this recommendation is attached) for my child listed above to prevent disruption of the adoption.

This additional PASSS funding will be used to complete the following services

I affirm, under penalty of perjury, that the information in this application is accurate. I understand that verification of my financial situation will be required. I understand and agree that the PCSA may contact other persons or organizations to obtain the necessary proof of eligibility and level of benefits. I understand that in some instances, I may be asked to give consent to the PCSA to make whatever contacts are necessary to determine eligibility. I consent to the release of this form and supporting documentation to the review committee established under Ohio Administrative Code rule 5101:2-44-13. I acknowledge that approval is contingent upon the availability of state funds for this program.

I understand that my application will be reviewed within twenty days after the quarter during the state fiscal year (SFY) in which it was approved. If the results of this review determine that the approved funds have not been utilized, I will be notified by the PCSA, within five days of the review, of their intent to release these funds. I will have twenty days to produce any outstanding invoices for that quarter. If the invoices are not submitted to the PCSA within the twenty days, the funds will be released to the Ohio Department of Job and Family Services and I will be financially responsible for any outstanding balances.

Signature of Adoptive Parent	Date	Signature of Adoptive Parent	Date

COMPLETION OF THIS FORM IS REQUIRED FOR ADDITIONAL POST ADOPTION SPECIAL SERVICES SUBSIDY FUNDS.

RIGHT TO A STATE HEARING: You have a right to a state hearing before the Ohio Department of Job and Family Services if your application is denied or if you disagree with any other actions taken on your application. For a complete explanation of your hearing rights and the hearing process, please read the JFS 04059 "Explanation of State Hearing Procedures". A copy of the JFS 04059 should be given to you along with this application form.

FOR AGENCY USE ONLY

This application complies with OAC Rule 5101:2-44-13.1 ☐ Yes ☐ No

This request is approved in the amount of $. This request is partially approved in the amount of $.

This request is denied due to: ☐ Extraordinary circumstance not established ☐ State funds not available ☐ Services not appropriate

☐ Age of the child ☐ Child is in the custody of a PCSA or PCPA ☐ Other

Signature of PCSA Director or Designee	Date

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POST ADOPTION SPECIAL SERVICE SUBSIDY (PASSS)

HEALTH INSURANCE INFORMATION
2018 – 2019

1. Does your child receive Medicaid? ☐ Yes ☐ No
2. Is your child covered by any private health coverage? ☐ Yes ☐ No
3. If yes, please list all insurance policies currently providing health coverage for your child as related to the services you are requesting:

Service Requested	In Network Policy	Out of Network Policy

If your child is covered by any insurance other than Medicaid, please attach a copy of the schedule of benefits for that plan. Your private insurance must process a claim for every requested service. Please include a copy of the denial letter or Explanation of Benefits (EOB). If you have not yet received a denial letter or EOB, please forward a copy upon receipt. If the service provider does not accept insurance, it is the responsibility of the family to submit a bill to their insurance carrier directly.

Name _____ Date _____ SCCS Worker _____ Date _____

Ohio Department of Job and family Services

APPLICANT FINANCIAL STATEMENT

Name *(Last, First Middle)*	Number of Dependent Adults *(Include self)*	Number of Dependent Children

The following information is being asked to assist you and the agency in your child placement planning. Please complete the financial statement using estimated monthly amounts.

A. MONTHLY INCOME

1. Family Member _____	Gross Pay per Month $_____	Net pay per month	$
2. Family Member _____	Gross Pay per Month $_____	Net pay per month	$
3. Other income (real estate, adoption subsidy, retirement, child support, public assistance, social security, etc.)			$
			$
			$
			$
			$
TOTAL NET MONTHLY INCOME			$

B. MONTHLY EXPENDITURES

1. Rent or mortgage (including taxes and insurances)	$
2. Utilities (including telephone)	$
3. Other fixed expenses	$
a. Child care	$
b. Car payments	$
c. Credit card payments	$
d. Other loan payments	$
e. Child support or alimony	$
f. Regular savings/investments	$
g. Other (specify)	$
TOTAL MONTHLY EXPENDITURES	$

COMPLETION OF THIS FORM IS REQUIRED FOR THE AGENCY TO PROCCED WITH YOUR APPLICATION FOR A CHILD.

C. ASSETS

	TOTAL VALUE
1. Residence Market value	$
2. Other real estate Market value	$
3. Cars – Specify	$
_____	$
_____	$
4. Savings	$
5. Stocks/Bonds	$
6. Other assets - Specify	$
TOTAL ASSETS	$

D. LIABILITIES

	BALANCE OWED
1. Residence mortgage	$
2. Other mortgage	$
3. Car loans	$
4. Other loans	$
5. Credit cards	$
6. Other	$
TOTAL LIABILITIES	$

E. INSURANCE COVERAGE

	Total Coverage Amount	Monthly Cost to Applicant	Company
Life Insurance	$	$	
Applicant _____	$	$	
Applicant _____	$	$	
Children _____	$	$	
Medical Insurance	$	$	
Automobile Insurance	$	$	
Other	$	$	

F. ANY PERTINENT INFORMATION NOT COVERED

_____

_____

_____

_____

_____

Applicant Signature	Date

Applicant Signature	Date

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POST ADOPTION SPECIAL SERVICE SUBSIDY (PASSS)

LETTER OF ATTESTATION – for Qualified Professionals

Post Adoption Special Service Subsidy (PASSS) SFY 2018-2019

A written statement from a qualified professional outlining the need for the requested service is mandatory. A qualified professional is defined by section 5101:2-44-13.1 of the ORC.

Child's Name: _____ DOB: _____

Parent's Name: _____

1. **What is the child's presenting problem and diagnosis?**

2. **What is your opinion as to the origin of the problem?**

3. **What is the child's prognosis and what are your recommendations related to future treatment needs?**

4. **What services are being recommended? What is the duration and frequency of the recommended service? What is the cost of the service?**

5. **What CPT billing code(s) should be used for the recommended service?**

6. **If you have already provided services to this child, what progress has been made thus far?**

7. **Additional Comments:**

8. **Please attach a treatment plan (*if applicable)* to this form.**

_____ _____
Please print your name and credentials Date

_____ _____
Your Signature Date

_____ ( )
Address (City, State & Zip) Phone

Ohio Department of Job and Family Services

CREDENTIALS OF PROFESSIONAL PROVIDERS OF PASSS FUNDED THERAPEUTIC SERVICES AND MEMORANDUM OF UNDERSTANDING

Child's Name *(first and last)*	Date of Birth
Specify the therapy being provided to the child	
Professional Experience (please describe your professional experience with the therapy you will provide to the child)	
Education and Training (please list all specific education and training relative to the therapy you will provide to the child)	
Professional Credentials	
Name of Provider *(first and last)*	
Name of Practice/Office	
Street Address of Practice/Office	
City, State and Zip Code	(Area Code) Telephone Number
Ohio License #	Licensing Board
My therapeutic interventions will comply with all treatment aspects contained in Ohio Administrative Code rules 5122-26-16 "Special treatment and safety measure," 5122-26-16.1 "Mechanical restraint and seclusion," 5122-26-16.2 "Physical restraint" and 5122-26-16.3 "Aversive behavioral interventions and plans." I proclaim competence to the therapeutic technique(s) specified and acknowledge that my practice is governed under laws and rules of the occupational regulatory board specified above.	
Signature of Provider of Services(s)	Date

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POST ADOPTION SPECIAL SERVICE SUBSIDY (PASSS)

RESPITE PROVIDER INFORMATION
2018-2019

Child's Name _____ Date _____

Provider Name _____ ( ) Phone _____

(Note: Your provider CANNOT live in your home)

Provider Address _____

City, State & Zip Code _____

Provider Rate: $ _____ Per Hour $ _____ Per Day

Is this provider a relative? ☐ Yes ☐ No

If Yes, explain why this person is the only provider who is qualified to watch your child:

NOTE: Respite Care services are designed to provide temporary relief of childcare functions. They do not include regular childcare while parents are working. The respite provider cannot live in the home. Relative caregivers are prohibited unless given special approval by the PASSS committee on a case by case basis. **Without special approval, your relative provider will not be paid.**

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POST ADOPTION SPECIAL SERVICE SUBSIDY (PASSS)

RESPITE REIMBURSEMENT

PROVIDER

Provider of Service **Name:** _____

Provider of Service **Address:** _____

City, State & Zip Code: _____

Provider of Service **Phone No.:** ( ) _____

ADOPTIVE PARENT

Name of Child: _____

Adoptive Parent **Name:** _____

Adoptive Parent **Address:** _____

City, State & Zip Code: _____

Adoptive Parent **Phone No.:** ( ) _____

Is Provider: *(check one)* ☐ Family ☐ Non-Family
Approval for family provider ***must be*** granted in advance by the PASSS Committee.

Dates of Service	**Beginning Time**	**Ending Time**	**Total Time**		**Rate Per Hour**		**Charge Per Day**
				X		=	
				X		=	
				X		=	
				X		=	
				X		=	
				X		=	
				Total Charge		=	

Signature of Provider Date
(Serving as proof of, services were provided)

Signature of Adoptive Parent Date
(Serving as proof of, accurate charges)

Ohio Department of Job and Family Services

EXPLANATION OF STATE HEARING PROCEDURES

What is a State Hearing?

If you think there has been a mistake or delay on your case, you may want to ask for a state hearing. You can ask for a hearing about actions by either the state department of job and family services or the local agency. Local agencies include the County Department of Job and Family Services (CDJFS), the County Child Support Enforcement Agency (CSEA), and agencies under contract with them.

A state hearing is a meeting with you, someone from the local agency, and a hearing officer from the Ohio Department of Job and Family Services (ODJFS). The person from the local agency will explain the action it has taken or wants to take on your case. Then, you will have a chance to tell why you think the action is wrong. The hearing officer will listen to you and to the local agency, and may ask questions to help bring out all the facts. The hearing officer will review the facts presented at the hearing and recommend a decision based on whether or not the rules were correctly applied in your case.

How to Ask for a Hearing

To ask for a hearing, call or write your local agency or write to the Ohio Department of Job and Family Services, Bureau of State Hearings, PO Box 182825, Columbus, Ohio 43218-2825. If you receive a notice denying, reducing or stopping your assistance or services, you will receive a state hearing request form. Fill out the request form and mail it to State Hearings. You may also fax your hearing request to State Hearings at (614) 728-9574.

We must receive your hearing request within 90 days of the mailing date of the notice of action. However, if you receive food assistance, you may request a hearing on the amount of your food assistance at any time during your certification period.

If someone else makes a written request for you, it must include a written statement, signed by you, telling us that person is your representative. Only you can make a request by telephone.

How to Request a Telephone Hearing

If you cannot attend the hearing at the scheduled location as a result of not having transportation, child care, medical limitations, etc., you can call 1-866-635-3748 and choose to participate by telephone. If you participate by telephone, the hearing officer assigned to your appeal will call you on the day of your hearing at the scheduled time for your hearing at the telephone number you provide.

Continuing Assistance or Services

If you receive a notice that your assistance or services will be reduced, stopped, or restricted, you must request a state hearing within 15 days of receiving that notice in order to continue receiving your benefits until your hearing decision is issued.

In the food assistance program, your benefits will not continue if you were denied or if the certification period has expired. After the certification period, you must reapply and be found eligible.

If your assistance or services have been changed without written notice, or if the change was made even though you requested a timely hearing, you can call the Bureau of State Hearings, to inquire if you should receive continuing benefits. Call us, toll free at the following number: 1-866-635-3748, and choose option number one from the automated voice menu.

If your assistance is continuing and you lose the hearing, you may have to pay back any benefits that you were not eligible to receive.

The continuing assistance provisions described in this section do not apply to the child support program. If you request a hearing about child support services, your hearing request will have no effect on your receipt of services while your hearing is pending.

County Conference

An informal meeting with a person from the local agency may settle the issue without the need for a state hearing.

Often this is the quickest way to solve a problem. At this meeting your case will be reviewed with you. If a mistake has been made, it can be corrected without the need for a state hearing. You can set up a county conference by asking your county worker. If you are not satisfied with the results, you can still have a state hearing.

You do not have to have a county conference to have a state hearing. Asking for a county conference will not delay your state hearing.

When Will the Hearing be Held?

After your request for a hearing is received, the Bureau of State Hearings will send you a scheduling notice giving the date, time and place of the hearing. This notice will be sent to you at least 10 days before the hearing. The notice will also tell you what to do if you cannot come to the hearing as scheduled.

Where are Hearings Held?

Hearings are usually held at the local agency. If you are unable to go there, the hearing may be held some other place that is convenient to you and to the other people involved. If you want the hearing held somewhere other than the local agency, be sure to tell us that in your hearing request.

Postponement of the Hearing

If you cannot come to the hearing as scheduled, or if you need more time to prepare, you can ask the hearings section for a postponement. In the food assistance program, postponement is limited to 30 days from the date of the first scheduled hearing. In all other programs, you must have a good reason to postpone the hearing.

If You Do Not Attend the Hearing

The Bureau of State Hearings will send you a dismissal notice if you do not come to the hearing. If you want to continue with your hearing request, you must contact State Hearings within 10 days and explain why you did not come to the hearing along with any verification. Verifications are documents or papers that prove why you missed your scheduled hearing. Once you have submitted your good cause verification, the hearing authority will decide if the documentation you provide is sufficient. If you do not call within 10 days and show good cause or proof for missing the hearing, it will be dismissed and you will lose the hearing. The local agency can then go ahead with the action it was planning to take.

If you disagree with the dismissal, the dismissal notice will tell you how to ask for an administrative appeal.

Before the Hearing

You may have someone (lawyer, welfare rights person, friend or relative) go to the hearing to present your case for you. If you are not going to be at the hearing, the person attending for you must bring a written statement from you saying he or she is your representative.

If you want legal help at the hearing, you must make arrangements before the hearing. Contact your local legal aid program to see if you qualify for free help.

If you do not know how to reach your local aid office, call 866-529-6446 (866-LAW-OHIO), toll-free, for the local number or search the Legal Aid directory at http://www.ohiolegalservices.org/programs. If you want notice of the hearing sent to your lawyer, you must give the Bureau of State Hearings your lawyer's name and address.

You and your representative have the right to look at your case file and the written rules being applied to your case. If your hearing is about work registration or employment and training, you may also look at your employment and training file. You can get a free copy of any case record documents that are related to your hearing request. Any person acting for you must provide a signed statement from you before looking at your case record or receiving copies of case record documents.

The local agency does not have to show you confidential records, such as names of people who have given information against you, records of criminal proceedings, and certain medical records.

Confidential records which you could not look at or question cannot be presented at the hearing or be used by the hearing officer in reaching a decision.

Subpoena

You can ask the hearing authority to subpoena documents or witnesses that would not otherwise be available and are essential to your case. You must request the subpoena at least five calendar days before the date of the hearing and provide the name and the address of the person or document you want to subpoena.

At the Hearing

You may bring witnesses, friends, relatives, or your lawyer to help you present your case. The hearing officer may limit the number of witnesses allowed in the hearing at any one time if there is not enough room. You and your representative will have the right to look at the evidence used at the hearing, present your side of the case without undue interference, ask questions, and bring papers or other evidence to support your case.

The hearing will be recorded by the hearing officer so that the facts are taken down correctly. After the hearing decision is issued, you can get a free copy of the recording by contacting the Bureau of State Hearings.

The hearing officer will listen to both sides but will not make a decision at the hearing. Instead, you will receive a written decision in the mail issued by the hearing authority.

Group Hearings

The Bureau of State Hearings may combine several individual hearing requests into a single group hearing, but only if there is no disagreement about the facts of each case and all involve related issues of state or federal law or county policy. The notice to schedule your hearing will tell you if you are scheduled for a group hearing.

You and your representative will be allowed to present your own case individually and you will have the same rights at a group hearing as you would at an individual hearing.

After the Hearing

You should receive a hearing decision within 60 days of your hearing request if the hearing was only about food assistance, and within 90 days for all other programs.

If you disagree with the hearing decision, your written decision will tell you how to ask for an administrative appeal.

Compliance with the Hearing Decision

If the hearing decision orders an increase in your food assistance, you should get the increase about 10 days from the decision date. If the decision orders a decrease in your food assistance, you should get the new, smaller amount the next time you regularly get food assistance.

In all other programs, the agency must take the action ordered by the decision within 15 days of the date the decision is issued, but always within 90 days of your hearing request. Contact the Bureau of State Hearings if you have not promptly received the benefits awarded by the hearing decision.

Another Action Requires Another Hearing

If you receive another prior notice that says the local agency wants to change your assistance or services while you are waiting for a hearing or hearing decision, you must ask for another hearing if you disagree with the new action. A separate hearing will be conducted on the new notice.