

Ohio Department of Job and Family Services
**PUBLICLY FUNDED CHILD CARE
 MANUAL CLAIM FOR ATTENDANCE**

SECTION I. PROVIDER TO COMPLETE THIS SECTION <i>(please print)</i>				
Provider Name <i>(as printed on Certificate or License)</i>		Provider ID Number	Authorization Number	
Caretaker First Name	Caretaker Last Name		Case Number <i>(10 digits)</i>	
Child First Name	Child Last Name		Child IID Number <i>(12 digits)</i>	
SECTION II. REASON FOR MANUAL CLAIM <i>(check only one reason below for which services could not be completed within the back swipe period)</i>				
<input type="checkbox"/> Authorization prior to back swipe period (MCPB)		<input type="checkbox"/> Caretaker awaiting swipe card (MCAC)		
<input type="checkbox"/> State Hearing decision (MCSH)		<input type="checkbox"/> Caretaker withdraws without notice (MCCW)		
<input type="checkbox"/> POS device not installed (MCND)		<input type="checkbox"/> Caretaker failure to swipe (MCFS)		
SECTION III. ADDITIONAL INFORMATION <i>(include details regarding claim below)</i>				
SECTION IV. ABSENT DAY				
Enter Sunday Begin Date: _____ <i>(MM/DD/YYYY)</i> for the week of attendance you are submitting				
Please indicate day(s) of the week the Absent Day(s) requested and the date in the format of MM/DD/YYYY				
<input type="checkbox"/> Sun. _____ <input type="checkbox"/> Mon. _____ <input type="checkbox"/> Tues. _____ <input type="checkbox"/> Wed. _____ <input type="checkbox"/> Thurs. _____ <input type="checkbox"/> Fri. _____ <input type="checkbox"/> Sat. _____				
SECTION V. CARETAKER OR PROVIDER TO COMPLETE THIS SECTION <i>(please print)</i>				
Attendance <i>(enter in and out time including hours and minutes with AM or PM indicator)</i>				
Enter Sunday Begin Date: _____ <i>(MM/DD/YYYY)</i> 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 VI. SIGNATURES <i>(by signing below, I agree that my child was in care at this provider during the dates and times entered above)</i>				
Caretaker Signature <i>(not applicable if caretaker withdraws without notice)</i>			Date Caretaker Signs <i>(MM/DD/YYYY)</i>	
Caretaker Name <i>(please print)</i>			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 <i>(MM/DD/YYYY)</i>	
Provider/Designee Name <i>(please print)</i>			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				
<input type="checkbox"/> Check here if Manual Claim is denied and list reason below				