

Opportunities for Ohioans with Disabilities
Personal Care Assistance (PCA) Program
REIMBURSEMENT BILLING FOR EMPLOYMENT COSTS

PCA Program Participant's Name _____

Participant's Address (if changed) _____

Complete Section I or Section II quarterly and send to the address indicated on the bottom of this form as soon as possible after the end of a quarter. Please refer to complete instructions on the reverse side of this form.
PLEASE ATTACH APPROPRIATE DOCUMENTATION WITH REIMBURSEMENT REQUEST.

QUARTERS: 1: JAN-MAR 2: APR-JUNE 3: JULY-SEPT 4: OCT-DEC

SECTION I: I directly hire assistants and pay my employer taxes myself. I am requesting reimbursement for the following costs incurred as an employer:

TYPE OF EMPLOYER TAX	AMOUNT PAID	QUARTER				YEAR
		(CIRCLE ONE)				
Social Security (FICA) (employer's share)	\$ _____	1	2	3	4	_____
Medicare (employer's share)	\$ _____	1	2	3	4	_____
State Unemployment	\$ _____	1	2	3	4	_____
Workers' Compensation	\$ _____	1 & 2	3 & 4			_____
Federal Unemployment (FUTA)	\$ _____	1	2	3	4	_____
TOTAL REQUESTED FOR REIMBURSEMENT	\$ _____					

SECTION II: I use self-employed independent contractors or obtain assistants from a Home Health Agency. I am requesting reimbursement for the following costs charged by the contractors or employers.

		QUARTER				YEAR
		(CIRCLE ONE)				
Number of hours billed to PCA.	_____	1	2	3	4	_____
Rate per hour: (Difference between rate paid to Agency/contractor and amount reimbursed through OOD; up to \$1.00 per hour)	\$ _____					
Total Requested: (Hours x Rate)	\$ _____					

My signature certifies that the information on this form is correct:

PCA Participant's Signature  _____ Date Submitted _____

Send your billing with all appropriate documentation via mail, email, or fax:

Personal Care Assistance (PCA) Program
c/o Opportunities for Ohioans with Disabilities
400 E. Campus View Blvd.
Columbus, OH 43235-4604

Fax: 614-985-9678

Email: PCA@ood.ohio.gov

(See reverse side for instructions on completing this form)

OOD does not discriminate on the basis of age, color, national origin, race, sex, or type of disability.

INSTRUCTIONS

Use this form to request reimbursement for employer taxes either paid directly by you as the employer or paid indirectly through the fee assessed by a home health agency or independent contractor. You must complete either Section I and/or Section II and submit to the PCA Program quarterly.

Please follow the instructions carefully and complete only the section which applies to you. Most participants will not need to complete both sections.

INSTRUCTIONS FOR SECTION I:

1. This section is to be completed by participants who are considered to be EMPLOYERS of their assistants.
2. For each tax, enter the amount paid under the column "AMOUNT PAID". Circle the appropriate quarter and enter the year for which you are requesting reimbursement. FOR EXAMPLE: When requesting reimbursement for State Unemployment for April through June 2005, you would enter the amount shown due on the tax form under the first column, circle 2, and write 2005. When requesting reimbursement for Workers' Compensation for January through June 2005, enter the amount paid shown on the tax form, circle 1 & 2, and write 2005. Not all taxes are paid every quarter. Leave the space blank if you are not requesting reimbursement for a particular employer cost.

INSTRUCTIONS FOR SECTION II:

1. This section is to be completed by participants who use home health agencies and/or independent contractors and whose assessed rate is higher than the reimbursement rate received through the PCA Program.
2. Enter the number of hours for which you requested reimbursement through the PCA Program for a specific quarter.
3. Circle the quarter and enter the year for which you are submitting the reimbursement request.
4. To calculate the "Rate per hour." take the agency's fee per hour and subtract the hourly rate received through the PCA Program. If the difference is \$1.00 or greater, use \$1.00. If the difference is less than \$1.00, use the exact difference. Example: The agency's fee is \$10.00 per hour and the OOD rate is \$8.00 per hour ($\$10.00 - \$8.00 = \2.00) you bill \$1.00 per hour used. Example: The agency's fee is \$8.50 per hour and the OOD rate is \$8.00 ($\$8.50 - \$8.00 = \$.50$) you bill \$.50 per hour used.
5. Multiply the "Number of hours" times "Rate per hour" to determine the total amount requested.

ALL COSTS MUST BE DOCUMENTED. Documentation must be attached to provide proof of both the amount of the cost incurred and that the cost has been paid. For Section I, attach copies of the tax form for the specific tax for which you are requesting reimbursement. Since some taxes are not paid every quarter, you will not submit forms every quarter. Refer to your tax guide to determine which taxes are paid in each quarter.

For Section II, attach a copy of one of your bills from the agency or independent contractor from the quarter for which you are requesting reimbursement.

PROOF OF PAYMENT. Proof of payment may be submitted later than this form, but it must be provided before you request the next quarter's reimbursement. Proof of payment may be a copy of a canceled check, a copy of a money order receipt, a signed payment receipt, a letter from the taxing authority indicating payment was made, etc.

Sign the reimbursement billing, attach documentation, and mail to the PCA Program at the address indicated.