Ohio Department of Medicaid

VOLUNTARY COST SAVINGS PROGRAM (VCSP) AGREEMENT

Employee's Name	
Employee's Status	☐ Exempt ☐ Bargaining Unit: ☐ OCSEA ☐ 1199
Division/Office/Unit	
Estimated Cost Savings $	(hourly rate, multiplied by number of hours in VCS plan)

In accordance with section 123:1-34-10 of the Administrative Code, I am voluntarily requesting to participate in the following Voluntary Cost Savings Program:

☐ **Option 1 - Reduction of Hours (full-time employees only)**

I agree to a reduced work schedule beginning _____ *(MM/DD/YYYY)* and ending _____ *(MM/DD/YYYY)*

I understand that my supervisor and I must agree in writing on my work schedule.

☐ **Option 2 - Unpaid Leave of Absence (Minimum 2 weeks – Maximum period of 13 weeks)**

I agree to take an unpaid leave of absence beginning _____ *(MM/DD/YYYY)* and ending _____ *(MM/DD/YYYY)*

Cancellation Policy: An agreement under this program can be terminated by this office upon ten (10) working days' notice in writing to the employee. Such termination shall not be grievable/appealable. The employee may terminate this agreement upon ten (10) working days' notice in writing unless mutually agreed to otherwise.

I hereby acknowledge that I am **NOT** eligible to receive unemployment while participating in this program.

Employee Signature	**Date**

FOR AGENCY USE ONLY		
Calculated Fringe Cost		
Supervisor Signature	**Date**	
Bureau Chief Signature	**Date**	
Deputy Director Signature	**Date**	
Chief of Staff Signature	**Date**	☐ **Approved** ☐ **Denied**
Comments	**Date Stamp**	