Summit County Department of Job and Family Services

PRC Plan

APPENDIX C: FORMS (10/1/2025)

PRC Application:

Application for TANF services (SCDJFS 7158 rev 04/23)

Notices:

Applicant/Recipient Authorization for Release of Information (JFS 07341 rev 03/24)

Notice of Approval of Your Application for Assistance" (JFS 04074 rev 08/21)

Notice of Right to Request another Worksite or Provider of Service

Notice of Denial of Your Application for Assistance (JFS 07334 rev 05/24)

Prior Notice of Right to a State Hearing (JFS 4065 rev 10/23)

Department of Job and Family Services
Russell M. Pry Building
1180 S. Main Street, Suite 102
Akron, OH 44301-1256

844.640.OHIO (6446)
866.351.8292 *Fax*
SummitDJFS.org

E-mail your documents/verifications
SummitE-Docs@JFS.Ohio.gov

Temporary Assistance for Needy Families (TANF)

Application for TANF Services

Voter Registration Assistance – If you are not registered to vote where you live, would you like to apply to register today?

☐ **YES,** I want to register to vote ☐ **NO,** I do not want to register to vote. *(If you do not check either box, you will be considered to have decided not to register to vote at this time. Applying to register to vote or declining will not affect the amount of your assistance.)*

Name *(Last)*	*(First)*	*(MI)*
Address	**City, State, ZIP code**	
Telephone *(Home)*	*(Work)*	*(Message)*
E-mail address		

SCDJFS USE ONLY	
Type of PRC services ☐ Soft ☐ Hard ☐ NA	Date received
PRC in the last 12 months ☐ Yes ☐ No ☐ NA	Case number
PRC clearance	Funding source ☐ PRC ☐ Title XX/TANF
Application ☐ Approved ☐ Denied	Application source

Complete the section below for everyone living in your home, including yourself. You are required to verify all income for all members of your household. Use the back of this page to list additional household members.

Full name *(first and last)*	**Social Security number**	**Date of birth**	**Sex**	**Relationship to applicant**	**Source of monthly income** *(Employment, child support, OWF, VA check, SSI)*	**Monthly amount of gross income**
*				***SELF**		

Include additional household members on back if applicable

1. Have any household members listed above left the residence in the last 45 days? ☐ Yes ☐ No *If yes, who and what is their relationship to the applicant?*

2. Are you applying as a non-custodial parent? ☐ Yes ☐ No *If yes, list below the non-custodial address of child listed above*

3. Are you a U.S. citizen? ☐ Yes ☐ No
4. Are you, or is anyone in your household, pregnant? ☐ Yes ☐ No
5. Is anyone in your household a fugitive felon? ☐ Yes ☐ No
6. Has anyone in your family, including yourself, fraudulently received assistance under the OWF, PRC, and/or TANF programs? ☐ Yes ☐ No
7. What services are you requesting?

8. Are you a resident of Summit County, who is currently or was previously out of work, or working less than normal or experienced other financial hardships due to COVID-19? ☐ Yes ☐ No
9. Have you or any member of your household received emergency assistance in the last 12 months? ☐ Yes ☐ No

List the agencies you have contacted for assistance	**Did you receive help?**	**If the agency helped you, please explain how. If the agency did not help you, please explain why not.** *(Verification required)*
	☐ Yes ☐ No	
	☐ Yes ☐ No	

Continued ❯❯

Additional household members if applicable

Full name *(first and last)*	**Social Security number**	**Date of birth**	**Sex**	**Relationship to applicant**	**Source of monthly income** *(Employment, child support, OWF, VA check, SSI)*	**Monthly amount of gross income**

RECIPIENT ACKNOWLEDGMENT

Recipient hereby acknowledges that Title VI of the Civil Rights Act of 1964 (Title VI) and its implementing regulations provides that no person shall be subjected to discrimination on the basis of race, color, or national origin under any program or activity that receives federal financial assistance. Thus, any organization or individual that receives federal financial assistance, either directly or indirectly, through a grant, contract, or subcontract, is covered by Title VI, including hospitals, nursing homes, home health agencies, home maintenance organizations, health service providers, and human service organizations.

Recipient further acknowledges that Title VI makes it unlawful for an individual or an organization to discriminate against persons with limited english proficiency (LEP). Also, agencies who receive federal funding from the U.S. Department of Health and Human Services (HHS) are required to provide oral and/or written translation services to individuals whose primary language (spoken or written) is not English. Agency warrants that, if an individual or organization is a recipient of federal financial assistance from HHS, it has an obligation to ensure that LEP persons have meaningful and equal access to benefits and services.

Recipient agrees that to comply with all federal laws and regulations pertaining to Title VI of the Civil Rights Act of 1964.

MY SIGNATURE ACKNOWLEDGES that final approval of my TANF request is based on established guidelines and availability of TANF funds; it is also subject to the approval of the director. Misuse of TANF assistance is subject to recovery by the Investigations Unit following the procedures listed in the SCDJFS Fraud Plan.

I am authorizing the exchange of information between SCDJFS and any designated provider.

▸ _____ ▸ _____

Applicant signature **Date**

PROVIDER USE ONLY

PRC services provider name	**Name of contact person**	**Telephone number**	**Date received**

Program name(s)

SUMMARY OF ELIGIBILITY CRITERIA

The following summary is a checklist of items that must be verified to determine eligibility.

☐ Identity ☐ Citizenship ☐ Residency ☐ SCDJFS IPV checked _____ by _____ or ☐ N/A
Date *(SCDJFS representative)*

Economic need *(check one)*

☐ Services do not require verification of economic need ☐ Federal means-tested program: _____
(Program name)

☐ Gross monthly income ☐ No income reported *(per client statement of daily living expenses)*

Monthly earned income		**Monthly unearned income**		**Total gross monthly income**	**Assistance-group size**
$	+	$	=	$	

Eligibility status

☐ Approved ☐ Denied ☐ Notice of action sent by _____ _____
(Provider representative) *(Date)*

Services provided by community partners

☐ Rent $_____ ☐ Security deposit $_____ ☐ Utilities $_____

☐ Other $_____ *Explain* _____

Voter Registration and Information Update Form

Please read instructions carefully. Please type or print clearly with blue or black ink.
For further information, you may consult the Secretary of State's website at: VoteOhio.gov or call 877-SOS-OHIO (877-767-6446).

Eligibility

You are qualified to register to vote in Ohio if you meet all the following requirements:

1. You are a citizen of the United States.
2. You will be at least 18 years old on or before the day of the general election.
3. You will be a resident of Ohio for at least 30 days immediately before the election in which you want to vote.
4. You are not incarcerated (in jail or in prison) for a felony conviction.
5. You have not been declared incompetent for voting purposes by a probate court.
6. You have not been permanently disenfranchised for violations of election laws.

Use this form to register to vote or to update your current Ohio registration if you have changed your address or name.

NOTICE: This form must be received or postmarked by the 30th day before an election at which you intend to vote. You will be notified by your county board of elections of the location where you vote. If you do not receive a notice following timely submission of this form, please contact your county board of elections.

Please see information on back of this form to learn how to obtain an absentee ballot.

Numbers 1 and 2 below are required by law. You must answer both of the questions for your registration to be processed.

Identification Requirements

If you have a current Ohio driver's license or state ID card, you must provide that number on line 10. If you do not have an Ohio driver's license or state ID card, you must provide the last four digits of your Social Security number on line 10. If you have neither, please write "None."

Residency Requirements

Your voting residence is the location that you consider to be a permanent, not a temporary, residence. Your voting residence is the place in which your habitation is fixed and to which, whenever you are absent, you intend to return. If you do not have a fixed place of habitation, but you are a consistent or regular inhabitant of a shelter or other location to which you intend to return, you may use that shelter or other location as your residence for purposes of registering to vote. If you have questions about your specific residency circumstances, you may contact your local board of elections for further information.

Your Signature

In the area below the arrow in Box 14, please write your cursive, hand-written signature or make your legal mark, taking care that it does not touch the surrounding lines so when it is digitally imaged by your county board of elections it can effectively be used to identify your signature.

WHOEVER COMMITS ELECTION FALSIFICATION IS GUILTY OF A FELONY OF THE FIFTH DEGREE

I am: ☐ **Registering as an Ohio voter** ☐ **Updating my address** ☐ **Updating my name**

1. Are you a U.S. citizen? ☐ **Yes** ☐ **No**

2. Will you be at least 18 years of age on or before the next general election? ☐ **Yes** ☐ **No**

If you answered NO to either of the questions, do not complete this form.

3. Last Name	First Name	Middle Name or Initial	Jr., II, etc.

4. House Number and Street (Enter new address if changed)	Apt. or Lot #	5. City or Post Office	6. ZIP Code

7. Additional Mailing Address (if necessary)	8. County (where you live)

9. Birthdate (MM/DD/YYYY) (required)	10. Ohio driver's license number, state ID card number, OR last four digits of Social Security number (one form of ID required to be listed or provided)	11. Phone Number (voluntary)

12. **PREVIOUS ADDRESS IF UPDATING CURRENT REGISTRATION** - Previous House Number and Street

Previous City or Post Office	Previous County	Previous State

13. **CHANGE OF NAME ONLY** Former Legal Name	Former Signature

14. I declare under penalty of election falsification I am a citizen of the United States, will have lived in this state for 30 days immediately preceding the next election, and will be at least 18 years of age at the time of the general election.

Your Signature ↓ **Date** (MM/DD/YYYY) _____

FOR BOARD USE ONLY
SEC4010 (rev. 2/7/23)

City, Village, Twp.

Ward

Precinct

School Dist.

Cong. Dist.

Senate Dist.

House Dist.

TO ENSURE YOUR INFORMATION IS RECEIVED, PLEASE DO THE FOLLOWING:

1. Print this form.
2. Make sure all required fields are complete.
3. Sign and date your form.
4. Fold and insert your form into an envelope.
5. Mail your form to your county board of elections.

For your county board's address please visit VoteOhio.gov/Boards

If you have additional questions, please call the office of the Ohio Secretary of State at 877-SOS-OHIO (877-767-6446).

HOW TO O□TAIN AN OHIO A□SENTEE □ALLOT

You are entitled to vote by absentee ballot in Ohio without providing a reason. Absentee ballot applications may be obtained from your county board of elections or from the Secretary of State online at VoteOhio.gov or by phone at 877-SOS-OHIO (877-767-6446).

OHIO VOTER IDENTIFICATION RE□UIREMENTS

Voters must bring photo identification to the polls in order to verify identity. Voters who do not provide identification will still be able to cast a provisional ballot pursuant to R.C. 3505.181. For more information on voter identification requirements, please visit the Secretary of State□s website at VoteOhio.gov or call 877-SOS-OHIO (877-767-6446).

WHOEVER COMMITS ELECTION FALSIFICATION IS GUILTY OF A FELONY OF THE FIFTH DEGREE.

Department of Job & Family Services

APPLICANT/RECIPIENT AUTHORIZATION FOR RELEASE OF INFORMATION

FOR APPLICANTS/RECIPIENTS (or their Authorized Representative) ONLY:
Complete the information on Page 1.
If you are a Person Giving Information (NOT the applicant/recipient), please review Page 1 and fill out the boxes on Page 2.

Note: It is optional to complete this form, but this form will be used to determine your eligibility for SNAP, Cash, Medical, and/or Child Care Assistance benefits.

I ***(Name of applicant/recipient)*** _____ hereby give ***(Person/organization supplying information, ex: employer, landlord, etc.)*** _____ permission to release the information listed below to ***(Who will receive the information, ex: the county JFS office)*** _____ _____in order to determine my eligibility for Supplemental Nutrition Assistance Program (SNAP), Cash, Medical, and/or Child Care Assistance benefits, or for the following reason(s): _____

_____

Information to be released (ex: lease agreement): _____

_____

_____

Waiver Acknowledgements

By signing below, I understand that:

- This permission will end on ***(Date of "event" completion; "event" refers to the reason the signed authorization is needed)*** _____ or until I cancel it in writing, whichever happens first.
- I may revoke or cancel this consent at any time by sending written notice to my county JFS office. (County contact information can be found at *jfs.ohio.gov/County/*)
- Canceling this permission will not impact the use or disclosure of information that took place before the cancellation.
- Any information used or released because of this specific authorization may be disclosed again by the person or entity that receives it. In that case, the information may no longer be protected by federal or state law.
- This authorization is NOT for the release or use of Protected Health Information (PHI). The appropriate form to release PHI is the Authorization for the Release or Use of Protected Health Information (ODM Form 03397).
- I must honestly and completely report all facts relevant to my eligibility for SNAP, Cash, Medical, and/or Child Care Assistance benefits. I understand that if the requested information shows that I purposely incorrectly described my circumstances, the information may be forwarded to a prosecuting attorney for possible civil or criminal prosecution.

Signature of Applicant/Recipient OR Authorized Representative	**Date**

Title of Authorized Representative or Relationship to Applicant/Recipient (Parent, Guardian, Power of Attorney, etc.)

For Person/Organization Supplying Information: Please fill out the boxes below.

In the space below, please share any relevant information or attach verification documents that relate to the "Information to be Released" field at the top of Page 1.

Signature of Person Supplying Information	**Date**

Title of Person Supplying Information	Phone Number

Office Use ONLY

Applicant/Recipient Name	Case Number	
Name of County JFS Representative	Unique Identifier	Date

Ohio Department of Job and Family Services

NOTICE OF APPROVAL OF YOUR APPLICATION FOR ASSISTANCE

(Do not use to approve food assistance benefits)

Name	Case Name	
Street Address	Case Number	Program
City, State, and Zip Code	County	Mailing Date

We approved your _____ application dated _____.

Starting _____ you will get _____.

The people affected by this action are _____.

The reason for this action is _____.

The rules that require this action are _____.

Caseworker	District.	Telephone Number

Your Right to a State Hearing

This notice tells you what we are doing on your case. Contact your caseworker if you do not understand this notice. We can explain it. We also may be able to change what we are doing.

IF YOU DISAGREE WITH THIS DECISION, YOU CAN ASK FOR A STATE HEARING

Ask for a State Hearing: You can ask for a state hearing, if you disagree with the agency's action or think that the agency may have made a mistake. If you want a hearing, the Ohio Department of Job and Family Services (ODJFS) must receive your request 90 days from the date this notice was mailed to you. If the 90th day falls on a holiday or weekend, the deadline will be the next work day.

You can ask your local Legal Aid program for free help with your case. Contact your local Legal Aid office by phoning 1-866-LAW-OHIO (1-866-529-6446) or by searching the Legal Aid directory at http://www.ohiolegalservices.org/programs on the internet.

If someone is helping you with your case, ODJFS will need a signed "authorized representative" notice from you saying it's okay for that person to represent you for the hearing process.

On the Day of the State Hearing: You, or someone else helping you with your case, can explain the reason(s) why you don't think the decision is right. The agency proposing the action will explain its reasons. Then, an ODJFS hearing officer will make a decision after the hearing.

Case Name	Case Number	Mailing Date

If you disagree with the information on this notice and you wish to request a state hearing, follow these steps:

Step 1: Read, sign, date, and fill in your telephone number. Another person may sign this for you, if they send us your signed "authorized representative" notice.

Signature	Date	Telephone Number

Step 2: What program(s) is your hearing for? *(Check all that apply.)*

- ☐ OWF (cash assistance)
- ☐ Medicaid
- ☐ Medicaid Waiver Services
- ☐ Child Care (Title XX)
- ☐ Medicaid - Prior Authorization
- ☐ Medicaid - Disability Determination
- ☐ Prevention, Retention, and Contingency (PRC)
- ☐ Child Support (Title IV-D)
- ☐ Medicaid - Managed Care

Fill out this information, only if applies to your situation.

- ☐ I want to do my hearing by telephone. The phone number to call is _____.
- ☐ I need an interpreter at my state hearing. The language needed is _____.
- ☐ I am not available for a hearing on _____.
  (Please note: ODJFS may not be able to give you the preferred date.)
- ☐ I want a County Conference. (This is a meeting to discuss your case with your local agency.)
- ☐ This person has agreed to help me with my state hearing (my "authorized representative")

Name	Telephone Number
Address	Fax
City, State, Zip	Email

ODJFS must receive your request 90 days from the date this notice was mailed to you. You must choose one of the following ways to send this state hearing request to us. You should keep proof of when and how you sent this hearing request to us.

Please only submit your hearing request one time.

Electronically - Submit the hearing request to the Bureau of State Hearings SHARE Portal at https://hearings.jfs.ohio.gov/SHARE Log into the SHARE Portal using your Ohio Benefits ID and password to submit your request. (If you do not have an Ohio Benefits account, sign up at ssp.benefits.ohio.gov); or

Email - Email the ODJFS Bureau of State Hearings at bsh@jfs.ohio.gov. In the subject, put "State Hearing Request". In the message, put all of the information from the boxes at the top of this page and any additional information below; or

Phone - Phone the ODJFS Consumer Access Line at 866-635-3748. Follow the instructions for State Hearings. Mention this notice; or

Fax - Fax **both pages** of this notice to the ODJFS Bureau of State Hearings at (614) 728-9574; or

Mail - Mail **both pages** of this notice to ODJFS Bureau of State Hearings, P.O. Box 182825, Columbus, Ohio 43218-2825.

Contact your caseworker - It is better to send this request using one of the other methods above. But, you may give this page (completed and signed) to your caseworker. Or, you may phone your caseworker. Mention this notice.

Department of Job and Family Services

Notice of Right to Request Another Worksite or Provider of Services

Assistance Group Name	Case/Cat./Seq/	Date Notice Given

Read all of this information before you sign your name. If you do not understand any part of this document, ask for help before signing. A copy of this information will be given to you for your records.

The County Department of Job and Family Services (CDJFS) has agreements with other agencies to provide services to families who may be receiving Prevention, Retention and Contingency (PRC) or act as worksites to families receiving Ohio Works First (OWF). Some of the services or worksites may be held at religious agencies, such as churches.

If you do not want to go to a religious agency for services or as your worksite, tell your worker at the CDJFS. Your worker must provide you with another agency for your worksite or to provide services. Your caseworker will tell you how long it will take to find another agency.

If you do not understand this notice, contact your caseworker.

I received a copy of, and I have read, my Notice of Right to Request Another Worksite or Provider of Services, or it has
been read to me, and I understand it.

Signature of Applicant or Authorized Representative	Date

Ohio Department of Job and Family Services

NOTICE OF DENIAL OF YOUR APPLICATION FOR ASSISTANCE

Name	Assistance Group	
Street Address	Case Number	Program
City, State, and Zip Code	County	Mailing Date

We denied your _____ application dated _____

The people affected by this action are _____

The reason for this action is _____

The rules that require this action are _____

Caseworker	Worker I.D.	Telephone Number *(###) ###-####*

Your Right to a State Hearing

This notice tells you what we are doing on your case. Contact your caseworker if you do not understand this notice. We can explain it. We also may be able to change what we are doing.

IF YOU DISAGREE WITH THIS DECISION, ASK FOR A STATE HEARING

Ask for a State Hearing: You can ask for a state hearing, if you disagree with the County Department of Job and Family Services' (CDJFS) action or think the CDJFS may have made a mistake. If you want a hearing, the Ohio Department of Job and Family Services (ODJFS) must receive your request 90 days from the date this notice was mailed to you. If the 90th day falls on a holiday or weekend, the deadline will be the next work day.

You can ask your local Legal Aid program for free help with your case. Contact your local Legal Aid office by phoning 1-866-LAW-OHIO (1-866-529-6446) or by searching the Legal Aid directory at http://www.ohiolegalservices.org/programs on the internet.

If someone is helping you with your case, ODJFS will need a signed "authorized representative" notice from you saying it's okay for that person to represent you for the hearing process.

On the Day of the State Hearing: You, or someone else helping you with your case, can explain the reason(s) why you don't think the decision is right. The agency will explain its reasons. Then, an ODJFS hearing officer will make a decision after the hearing.

AG Name	Case Number	Mailing Date

Step 1: Read, sign, date, and fill in your telephone number. Another person may sign this for you, if they send us your signed "authorized representative" notice.

Sign Here	Date	Telephone Number *(###) ###-####*

Step 2: What is your hearing for? *(Check all that apply.)*

- ☐ OWF (cash assistance)
- ☐ SNAP (food assistance)
- ☐ Medicaid
- ☐ Medicaid Waiver Services
- ☐ Child Care (Title XX)
- ☐ Medicaid - Disability Determination
- ☐ Medicaid - Prior Authorization
- ☐ Prevention, Retention, and Contingency (PRC)
- ☐ Child Support (Title IV-D)
- ☐ Medicaid - Managed Care

Step 3: Fill out the information, as it applies to your situation.

- ☐ I want to do my hearing by telephone. Phone Number _____
- ☐ I need an interpreter at my state hearing. Language _____
- ☐ I am not available for a hearing on: _____

(Please note: ODJFS may not be able to give you the preferred date.)

- ☐ I want a County Conference. (This is a meeting to discuss your case with your local agency.)
- ☐ This person has agreed to help me with my state hearing (my "authorized representative")

Name	Telephone Number *(###) ###-####*
Address	Fax *(###) ###-####*
City, State, Zip	Email

Step 4: ODJFS must receive your request 90 days from the date this notice was mailed to you. You must choose one of the following ways to send this state hearing request to us. You should keep proof of when and how you sent this hearing request to us.

Please only submit your hearing request one time. Return both pages of this notice.

Electronically - Submit the hearing request to the Bureau of State Hearings SHARE Portal at https://hearings.jfs.ohio.gov/SHARE Log into the SHARE Portal using your Ohio Benefits ID and password to submit your request. (If you do not have an Ohio Benefits account, sign up at ssp.benefits.ohio.gov); or

Email - Email the ODJFS Bureau of State Hearings at bsh@jfs.ohio.gov. In the subject, put "State Hearing Request". In the message, put all of the information from the boxes at the top of this page and from Steps 1, 2, and 3; or

Phone - Phone the ODJFS Consumer Access Line at 866-635-3748. Follow the instructions for State Hearings. Mention this notice; or

Fax - Fax both pages of this notice to the ODJFS Bureau of State Hearings at (614) 728-9574; or

Mail - Mail all pages of this notice to ODJFS Bureau of State Hearings, P.O. Box 182825, Columbus, Ohio 43218-2825.

Contact your caseworker - It is better to send this request using one of the other methods above. But, you may give this page (completed and signed) to your caseworker. Or, you may phone your caseworker. Mention this notice.

Ohio Department of Job and Family Services

PRIOR NOTICE OF RIGHT TO A STATE HEARING

Name	Case Name	
Street Address	Case Number	Program
City, State, and Zip Code	County	Mailing Date

We are proposing to make the following changes in your assistance. If you do not agree with this proposal and request a hearing by _____ this action will not be taken until the state hearing is decided. (For a full explanation of your hearing rights, see the second page of this notice.)

Termination of Benefits:

☐ The following benefits will be stopped: _____

- ☐ Your _____benefit will stop on _____.
- ☐ Your SNAP benefit will stop on _____.
- ☐ Your Medicaid will stop on _____.

☐ The following services will stop on _____

Services:

Reduction of Benefits:

☐ The following benefits will be reduced:

- ☐ Your _____ benefit be reduced from $_____ to $_____ on _____.
- ☐ Your SNAP benefit will be reduced from $ _____ to $_____ on _____.

☐ The _____ allowance will be reduced from $ _____ to $_____ on _____.

☐ The following services will be reduced from _____ to _____ on _____.

Services:

Suspension, Increase or Change in Benefits:

☐ The following action will be taken:

- ☐ Your _____ benefit will be increased from $_____ to $_____ on _____.
- ☐ Your Medicaid card for the month of _____ will be held and not mailed.
- ☐ Your _____ benefit will be suspended effective _____.

☐ Your Medicaid will be suspended effective _____.

☐ Other *(explain)*:

The reasons for this proposed action are:

The rules that require this action are:

If you do not understand this proposed action or you want to talk to your caseworker about it, you may call:

Caseworker	District/ID	Telephone Number

Case Name	Case Number	Mail Date

Your Right to a State Hearing
If you disagree with this action, you have the right to a state hearing. A state hearing lets you or your representative (lawyer, friend or relative) give your reasons against this action. The agency proposing the action will also attend the hearing to present its reasons. A hearing officer from the Ohio Department of Job and Family Services will decide whether you or the county agency is right. If you win your hearing the action may not be taken or you could get an increase in your benefits. If you lose your hearing, you may have to pay back money or food stamps that you received but were not eligible to receive. **You do not need to return this form if you agree with the proposed action.**

If someone else makes a written hearing 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.

If you want information on free legal services, but don't know the number of your local legal aid office, you can contact your local Legal Aid office in Ohio by calling 1-866-529-6446.

I want a state hearing.

Signature	Date	Telephone Number

Fill out this information, only if applies to your situation. *(Check all that apply)*

- ☐ I want to do my hearing by telephone. The phone number to call is _____.
- ☐ I need an interpreter at my state hearing. The language needed is _____.
- ☐ I am not available for a hearing on _____.
  (Please note: ODJFS may not be able to give you the preferred date.)
- ☐ I want a County Conference. (This is a meeting to discuss your case with your local agency.)
- ☐ This person has agreed to help me with my state hearing (my "authorized representative").

Name	Telephone Number ( )
Address	Fax ( )
City, State and Zip Code	Email

ODJFS must receive your request 90 days from the date this notice was mailed to you. You must choose one of the following ways to send this state hearing request to us. You should keep proof of when and how you sent this hearing request to us.

Please only submit your hearing request one time and include both pages of this notice.

Electronically - Submit the hearing request to the Bureau of State Hearings SHARE Portal at https://hearings.jfs.ohio.gov/SHARE Log into the SHARE Portal using your Ohio Benefits ID and password to submit your request. (If you do not have an Ohio Benefits account, sign up at ssp.benefits.ohio.gov); or
Email - Email the ODJFS Bureau of State Hearings at bsh@jfs.ohio.gov. In the subject, put "State Hearing Request". In the message, put all of the information from the boxes at the top of this page and any additional information below; or
Phone - Phone the ODJFS Consumer Access Line at 866-635-3748. Follow the instructions for State Hearings. Mention this notice; or
Fax - Fax **both pages** of this notice to the ODJFS Bureau of State Hearings at (614) 728-9574; or
Mail - Mail **both pages** of this notice to ODJFS Bureau of State Hearings, P.O. Box 182825, Columbus, Ohio 43218-2825.
Contact your caseworker - It is better to send this request using one of the other methods above. But, you may give this page (completed and signed) to your caseworker. Or, you may phone your caseworker. Mention this notice.