Ohio Department of Job and Family Services

STATE HEARING REQUEST

(For county or state use only)

Name			Case Number
Street Address			County of Residence
City	State	Zip	Primary Phone Number
Email Address			Alternate Phone Number

If customer agrees to have an **AUTHORIZED REPRESENTATIVE, complete the contact information below:**

Name			
Address	City	State	Zip
Phone Number(s)	Email Address		

What county/agency took the action the customer wants to appeal:

Was the customer notified in writing of the action? ☐ YES ☐ NO If "YES", what is the notice mail date? ____________________

Brief Explanation:

Check all that apply:

☐ Customer wants the Bureau of State Hearings to help work out issue(s) with the county agency before the hearing.

☐ Customer wants a county conference, so the customer can try to work out issue(s) with the county agency before the hearing.

☐ Customer would like to participate by phone.

☐ Customer needs an interpreter. I speak: ____

CASH ASSISTANCE

Is this about an ☐ APPROVAL ☐ DENIAL ☐ TERMINATION ☐ DELAY ☐ BENEFIT AMOUNT ☐ OVERPAYMENT

☐ Check here if the customer applied for or receives disability financial assistance.

☐ Check here if the customer's work allowance is at issue.

Is this about a SANCTION? ☐ YES ☐ NO If "YES", is sanction for ☐ WORK ACTIVITY or ☐ CHILD SUPPORT Cooperation

FOOD ASSISTANCE

Is this about an ☐ APPROVAL ☐ DENIAL ☐ TERMINATION ☐ DELAY ☐ BENEFIT AMT ☐ SANCTION ☐ OVERPAYMENT

☐ Check here if the customer applied for expedited food assistance.

☐ Check here if the customer's work allowance is at issue.

☐ Check here if the customer does not want continuing benefits.

MEDICAID

1. What type of Medicaid did/does the customer receive?

☐ Medicaid for parents or parent caretakers with children

☐ Medicaid for adults age 19 through age 64

☐ Medicaid for children up to age 19

☐ Medicaid for pregnant women only

☐ Medicaid for older adults (65 and over)

☐ Medicaid for people living with a disability

☐ Waiver *(specify)*: ____

☐ Medicare premium assistance (QMB, SLMB, QI-1)

☐ Nursing Home Care

☐ Preadmission Screening and Resident Review (PASRR)

☐ Medicaid for people living with blindness ☐ Another Medicaid program: ______________________________

2. Is this about an ☐ APPROVAL ☐ DENIAL ☐ TERMINATION ☐ REDUCTION

3. List customer's managed care plan here *(if applicable)*: ______________________________

4. Is this about an **ELIGIBILITY ISSUE** related to: *(select one)*

☐ Disability determination

☐ Amount/Release of Medicaid SPENDDOWN

☐ Ineligibility due to SANCTION

☐ Ineligibility due to CHILD SUPPORT Cooperation

☐ Managed Care Enrollment

5. Is this about a **SERVICE ISSUE** related to: *(select one)*

☐ PAYMENT of a Medicaid bill

☐ DENIAL of a service. Describe below:

____

☐ REDUCTION of a service. Describe below:

____

☐ Coordinated Services Program (CSP)

PROVISION, RETENTION, AND CONTINGENCY (PRC)

Is this about an ☐ APPROVAL/BENEFIT AMOUNT ☐ DENIAL ☐ DELAY

ADOPTION ASSISTANCE

1. Is this about an ☐ APPROVAL ☐ DENIAL ☐ TERMINATION ☐ SUBSIDY

2. What type of assistance did the customer apply for receive?

☐ Federal Adoption Assistance ☐ State Adoption Assistance ☐ Post Adoption Special Services Subsidy (PASSS)

☐ Kinship Permanency Incentive (KPI)

CHILD CARE

Is this about an ☐ APPROVAL ☐ DENIAL ☐ TERMINATION ☐ CO-PAYMENT AMOUNT ☐ OVERPAYMENT

CHILD SUPPORT

1. Is there a child support order in place? ☐ YES ☐ NO

2. Does the customer ☐ RECEIVE child support or ☐ PAY child support?

3. Check all that apply:

OBLIGEE	OBLIGOR
☐ The CSEA denied the application	☐ The CSEA denied paternity establishment services
☐ The CSEA did not act timely on the case	**OBLIGOR OR OBLIGEE**
☐ The obligee objects to case closure	☐ Either object to the results of a termination investigation
☐ The obligee has an issue with an overpayment	☐ The CSEA denied a request for modification
☐ The CSEA did not distribute or disburse collections correctly	
☐ The CSEA did not correctly assign the amount of arrears to ODJFS	

Please read the following instructions to the customer:

Your request is now entered into our system. If your request is approved, you will receive a scheduling notice of the date, time, and location of your hearing. If you have provided us with a valid phone number, you will also receive a phone call from the Bureau of State Hearings reminding you of your appointment. If your request is denied, you may request an administrative appeal. Please follow the instructions on the notice for more information.

Please note: If you have provided us with information regarding an authorized representative, you are agreeing that this person can represent you at your hearing and can take action on your case for you. Your authorized representative will need a signed authorization from you if you do not attend the hearing with your authorized representative.

If you would like to withdraw your hearing request, please call us back at 1-866-635-3748, and we can help you.

Also, if you have requested the Bureau of State Hearings help you with your case, you will receive a call from us. If you have requested a county conference, we will forward your request to the county for handling. If you need legal help with your hearing, you can contact your local bar association. If you want information on free legal help, you can contact your local legal aid office at 1-866-529-6446. That is 1-866-LAW-OHIO.

On the day of the hearing, please bring any important documents you may need for your hearing.

If you want to learn more about the state hearing process, please refer to the JFS 07501 Program Enrollment and Benefit Information booklet you received when you applied or reapplied for public assistance. May I provide you with any additional information regarding your hearing request?