

Program Application

Complete the chart below for anyone living in your home, including yourself. Income verification is required.

| First Name | | | Last Name | | | | | |
|-----------------|--------------|-------------------|---------------------------|---------------|--|------|-----------------------|------------------|
| Street Address | | | Cleveland | State | Zip Code | | | |
| Social Security | | Case # | | Date of Birth | | | | |
| Telephone# | | Citizenship | | Race | Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female | | | |
| Name | U.S. Citizen | Social Security # | Relationship to Applicant | Date of Birth | Sex | Race | Monthly Income Amount | Source of Income |
| | | | | | | | \$ | |
| | | | | | | | \$ | |
| | | | | | | | \$ | |
| | | | | | | | \$ | |
| | | | | | | | \$ | |
| | | | | | | | \$ | |
| | | | | | | | \$ | |

If any member of your household has any of the resources listed below, check yes beside the item and complete the line. Otherwise check no. Income verification may be required.

| Resource | Yes | No | Person with Resource | Amount |
|------------------|-----|----|----------------------|--------|
| Cash on Hand | | | | \$ |
| Savings Account | | | | \$ |
| Checking Account | | | | \$ |
| Trust Fund | | | | \$ |
| Stocks or Bonds | | | | \$ |
| Other, Specify | | | | \$ |

Any attempt to apply for benefits fraudulently shall be prosecuted under the Ohio Revised Code.

Applicant Signature _____ Date _____

Eligibility Determiner's Printed Name _____

Eligibility Determiner's Signature _____

NOTICE OF DECISION OF YOUR APPLICATION FOR PROGRAM ELIGIBILITY

| | |
|-----------------------|--|
| Name | SS# |
| Street Address | Case Number (if applicable) |
| City, State, Zip Code | Program <p style="text-align: center;">NEO-NAT</p> |

Mailing Date _____

Your application for Program Eligibility sign on _____ has been

Approved

 Denied

Reason: _____

The regulation supporting this decision is:

If you do not understand this notice, or want to talk to someone about it, you may call the EFS Hearings Department (216) 987-7205.

Your Right to a State Hearing

This notice is to tell you about action we are taking on your application. If you do not understand this action, you may contact the EFS Hearings Department. After talking with them, it is possible that we will change our decision or that you will agree with the action.

If you do not agree with this action, you have a right to a state hearing. A state hearing lets you or your representative (lawyer, welfare rights worker, friend, or relative) give your reasons against the action. We will also attend or be represented at the hearing to present our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

If you want a hearing, we must receive your hearing request within 90 days of the mailing date on this notice. You do not need to return this form if you agree with the 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 call the Ohio State Legal Services Association; toll free, at 1-800-589-5888, for the local number.

If you want a state hearing, check the appropriate boxes below, sign and date this form, and send it to the Ohio Department of Human Services, State Hearings, P.O. Box 182825, Columbus, Ohio 43218-2825.

- I want a county conference and a state hearing on this action.
- I want a state hearing only.

I want a hearing.

| | | |
|-----------|------|------------------|
| Signature | Date | Telephone number |
|-----------|------|------------------|