



## MERCER COUNTY GOOD CAUSE CRITERIA

- 0401** < **DOMESTIC VIOLENCE:** The Assistance Group's single parent/caretaker or minor Head of Household's ability to retain employment has been disrupted by Domestic Violence (within the last 3 months). Verification is required, such as court records, Law Enforcement records and evidence must demonstrate that the condition impacts the individual's ability to obtain/retain employment. The parent/caretaker must actively be seeking help to remedy the situation as evidenced by records of Family Crisis, a counselor or attorney. The parent/caretaker must continue to work to remedy the situation so that employment can be obtained/retained.
- 0101** < **LOSS OF EMPLOYMENT:** The assistance group has experienced a verified loss of income from full-time employment (ave. of 30 hrs. or more a week at minimum wage) due to plant/business closing or downsizing , a natural disaster or circumstances beyond the individual's control and Mercer County's unemployment rate has exceeded the State average for the past 3 months. The parent/caretaker must not have caused themselves to have been terminated from any employment.
- 0301** < **LOSS OF PRIMARY INCOME:** The single parent/caretaker documents loss of the Household's primary source of income due to legal separation/divorce or death within the last 3 months, has not worked in the past 2 years and has documented barriers to employment.
- 0501** < **BARRIERS TO EMPLOYMENT:** Inability of the single parent/caretaker to find employment due to documented barriers, such as lack of education (must be attending ABLE), physical or mental impairment (must have a pending SSI or disability application or appeal pending), drug or alcohol addictions (must be receiving treatment).. or other as deemed appropriate by MCJFS. The individual must provide verification that they are working to overcome these barriers.
- 0901** < **ILLNESS:** The single parent/caretaker or minor head of household is unable to maintain employment due to a serious/terminal illness of the adult assistance group member. Such illness must be medically verified. The MCJFS reserves the right to secure and rely upon a second opinion from a medical provider of its choice.
- 0801** < **CHILDCARE:** The single parent/caretaker loses access to childcare due to special needs of a child under the age of 18. The lack of childcare prevents the parent/caretaker from obtaining/retaining full time employment (30 hrs. or more a week at minimum wage). The assistance group must provide verification from a physician, psychologist, court records or Children's Services.
- 0502** < **CARE OF A MINOR, DISABLED CHILD:** The single parent/caretaker or minor Head of Household must provide medically necessary, full time care for a child in the assistance group. The medical necessity of the parent/caretaker's remaining in the home to care for the disabled child must be verified by a physician's statement. The MCJFS reserves the right to secure and rely upon a second opinion from a medical provider of its choice.
- 9054** < **TRANSFER:** OWF Good Cause case transferred in from another county.
- 1854** < **OTHER:** Any unique personal circumstance determined as Good Cause by the MCJFS Director and/or his designee(s).

**NOTE: IN TWO PARENT HOUSEHOLDS, BOTH PARENTS MUST MEET ONE OR MORE OF THE CONDITIONS SET FORTH IN THIS GOOD CAUSE CRITERIA.**

**MERCER COUNTY JOB and FAMILY SERVICES**

220 W. Livingston Street, Suite 10

Celina, Ohio 45822

Phone: (419) 586-5106

Fax: (419) 586-5643

e-mail: [mercerhs@mercercountyohio.org](mailto:mercerhs@mercercountyohio.org)

**REQUEST for GOOD CAUSE EXTENSION**

Head of Household Name: \_\_\_\_\_

Address: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

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I am requesting an extension of Ohio Works First assistance payments under the Good Cause Extension provisions. At least 24 months have passed since I reached my 36-month Ohio Works First time limit. I have been given a copy of Mercer County's Good Cause Criteria. I am requesting an extension because I feel that I meet the following criteria:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I understand that I must provide verification/documentation of the good cause that I am claiming and that all other eligibility requirements for Ohio Works First assistance must be met.

\_\_\_\_\_  
Head of Household Signature Date

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**Agency Use Only**

Time Limits Correct? Yes \_\_\_\_\_ No \_\_\_\_\_  
Hardship Months: \_\_\_\_\_  
Good Cause Months Remaining: \_\_\_\_\_

Verifications Requested/Provided: \_\_\_\_\_

\_\_\_\_\_  
Eligibility Referral Specialist Date

\*\*\*\*\*

Upfront Appraisal Completed Yes \_\_\_\_\_ No \_\_\_\_\_  
Self- Sufficiency Contract Signed Yes \_\_\_\_\_ No \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
Workforce Development Supervisor Date

\*\*\*\*\*

**GOOD CAUSE EXTENSION:** EXTENSION CODE (S): \_\_\_\_\_  
Approved \_\_\_\_\_ Denied \_\_\_\_\_ Date \_\_\_\_\_  
Date Notice/Hearing Rights sent: \_\_\_\_\_

\_\_\_\_\_  
Supervisor/Administrator Date Supervisor/Administrator Date

