

APPENDIX C: FORMS (Revised 01/13/16)

PRC Applications

PRC Application (SCDJFS 7158)

Approved Service Applications

Akron Community Action: Youth Build, Head Start
Bridges out of Poverty – Getting Ahead, The Guiding Coalition (Circles)
Child Support Job Readiness Programs
Free and Reduced-Price School Meal Program
LIHEAP
Nazareth Housing
InfoLine: Central Intake Form

Notices:

Notice of Right to Request Another Worksite or Provider of Service
Notice of Approval of Your Application for Assistance" (JFS 04074)
Notice of Denial of Your Application for Assistance (JFS 07334)
Applicant/Recipient Authorization For Release of Information (JFS 07341)



Department of Job and Family Services

47 N. Main Street • Akron, Ohio 44308-1991 • 330.643.8200

Prevention, Retention & Contingency (PRC) Application for PRC

Voter registration assistance

If you are not registered to vote where you live now, would you like to register to vote?

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.)

Name (Last)		(First)	(MI)
Address		Apt./Suite	
City		State	ZIP code
Telephone (Home)	(Work)	(Message)	

SCDJFS USE ONLY	
Type of PRC services <input type="checkbox"/> Soft <input type="checkbox"/> Hard	Date received
PRC in the last 12 months <input type="checkbox"/> Yes <input type="checkbox"/> No	Case number
PRC clearance	Application <input type="checkbox"/> Approved <input type="checkbox"/> 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.

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
Jonathan Smith (example)	123-45-6789	03/23/65	M	Brother	Employment, child support	\$1,500
*				*SELF		

Are you a U.S. citizen? Yes No

Are you, or is anyone in your household, pregnant? Yes No

Is anyone in your household a fugitive felon or in violation of probation or parole? Yes No

Has anyone in your family, including yourself, fraudulently received assistance under the OWF and/or PRC programs? Yes No

Is anyone in your household eligible for but not receiving court-ordered child support? Yes No

What services are you requesting?

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)
	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Continued >>>

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 PRC request is based on established guidelines and availability of PRC funds; it is also subject to the approval of the director. Misuse of PRC 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
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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

Monthly earned income \$ _____	+	Monthly unearned income \$ _____	=	Total gross monthly income \$ _____	Assistance-group size _____
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No income reported (per client statement of daily living expenses)

Eligibility status

Approved Denied

Notice of action sent by _____ (Date)
(Provider representative)

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: www.OhioSecretaryofState.gov or call 1-877-767-6446.

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.

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

Registering in Person

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

Registering by Mail

If you register by mail and do not provide either an Ohio driver's license number or the last four digits of your Social Security number, you must enclose with your application a copy of one of the following forms of identification:

Current and valid photo identification, a military identification, or a current (within the last 12 months) utility bill, bank statement, paycheck, government check or government document (other than a notice of voter registration mailed by a board of elections) that shows your name and current address.

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.

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

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

FOLD HERE

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

1. Are you a U.S. citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No	2. Will you be at least 18 years of age on or before the next general election? <input type="checkbox"/> Yes <input type="checkbox"/> 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 or P.O. Box (if necessary)	
8. County (where you live)		9. Birthdate (MO-DAY-YR) (required)	
10. Ohio Driver's License No. OR Last Four Digits of Social Security no. (one form of ID required to be listed or provided)		11. Phone No. (voluntary)	
12. PREVIOUS ADDRESS IF UPDATING CURRENT REGISTRATION - Previous House Number and Street			
Previous City or Post Office		County	
State		13. CHANGE OF NAME ONLY Former Legal Name	
Former Signature		Date	

FOR BOARD USE ONLY SEC4010 (Rev. 6/14) City, Village, Twp.
Ward
Precinct
School Dist.
Cong. Dist.
Senate Dist.
House Dist.

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 / /
 MO DAY YR

To ensure your information is updated, please do the following:

1. Print this form.
2. Complete all required fields.
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 www.OhioSecretaryofState.gov/boards.htm.

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

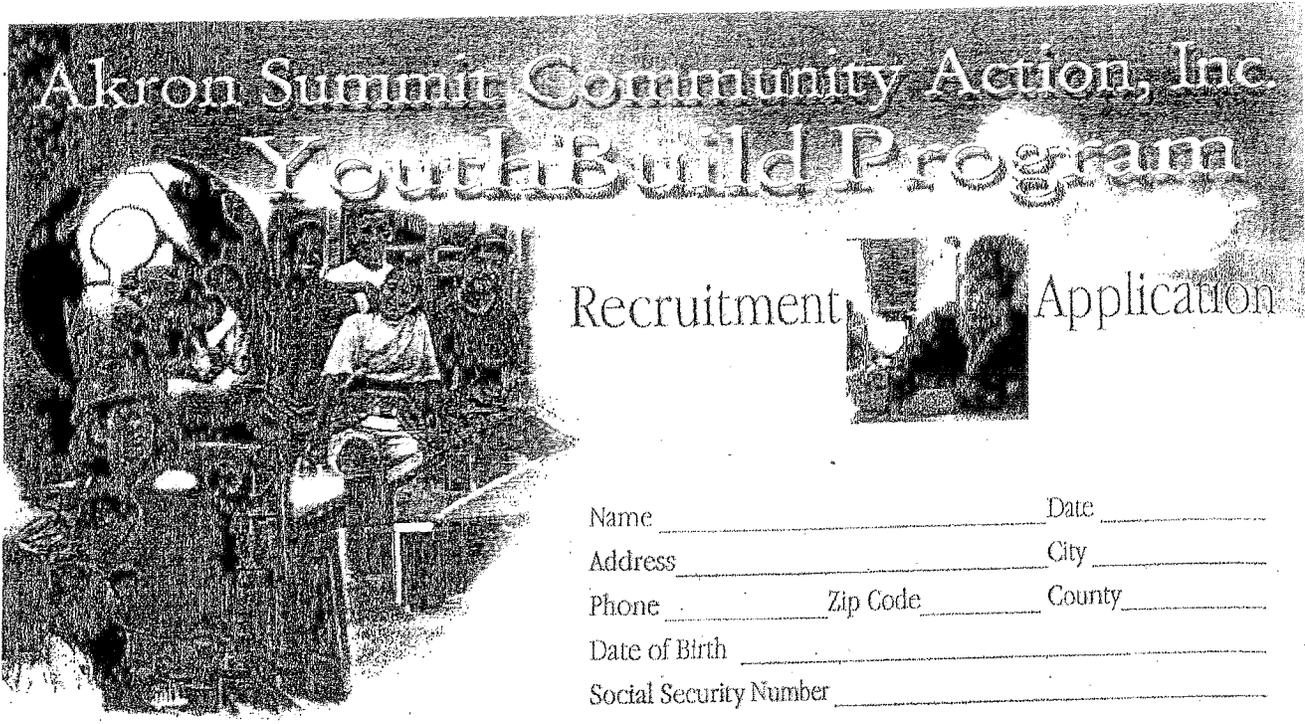
HOW TO OBTAIN AN OHIO ABSENTEE BALLOT

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 at: www.OhioSecretaryofState.gov or by calling 1-877-767-6446.

OHIO VOTER IDENTIFICATION REQUIREMENTS

Voters must bring identification to the polls in order to verify identity. Identification may include current and valid photo identification, a military identification, or a copy of a current (within the last 12 months) utility bill, bank statement, government check, paycheck, or other government document, other than a notice of an election or a voter registration notification sent by a board of elections, that shows the voter's name and current address. Voters who do not provide one of these documents will still be able to vote by providing the last four digits of the voter's Social Security number and by casting a provisional ballot pursuant to R.C. 3505.181. For more information on voter identification requirements, please consult the Secretary of State's website at: www.OhioSecretaryofState.gov or call 1-877-767-6446.

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



Recruitment Application

Name _____ Date _____
 Address _____ City _____
 Phone _____ Zip Code _____ County _____
 Date of Birth _____
 Social Security Number _____

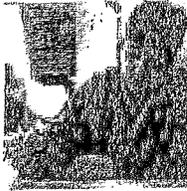
Where did you hear about YouthBuild?
 Newspaper Radio TV Flyer Business/Organization Other (write in) _____

1. Why are you interested in being in this program?

2. If you are accepted into the YouthBuild Program, you will be in class Monday through Friday, from 8:30 am to 4:00 pm, studying reading, writing, and math skills to help you prepare for a GED and for construction trades. Please express what you would like to get out of class?

Health
 Do you have any physical, medical or health problems? Yes No
 If yes, please describe:

Are you supposed to wear eyeglasses?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Do you have asthma?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Diabetes?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Do you smoke?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If you smoke, can you limit your smoking to breaks and lunchtime?	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>
Have you ever had a physical examination?	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>
If so, when was your last physical exam?		(Date)	_____



Education

Do you have a GED or high school diploma? Yes No
Last school attended _____ Highest grade completed _____ Last year in school _____
If you did not complete high school or get your GED, why did you drop out? _____

Did you take any shop courses in school? Yes No
If yes, please list courses taken _____

Do you know how to drive? Yes No
Do you own a car? Yes No
Do you have a Driver's/Operators License? Yes No
Do you have a Chauffer's/Commercial License? Yes No

Training and Work History

Have you ever been in another training program? Yes No
If yes, give name and location of program: _____

Dates you attended this program: _____
Did you complete this program? Yes No

Previous Employment

Have you ever held a job before? Yes No

Name of Company _____

Address of Company _____

Dates worked: From _____ To _____ Pay per week \$ _____

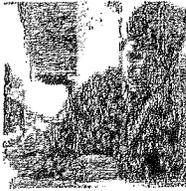
Job Title _____ Supervisors Name and Title _____

What kind of work did you do? _____

Why did you leave? _____



ASCA Recruitment



Application

Current Employment

Are you currently working?

Yes No

If so, are you working

Full time Part time Other _____

Current hourly wage rate:

\$ _____ Per hour

Number of hours worked per week: _____

Income received for the last six (6) months: _____

Construction Experience

Have you had any construction or rehab experience?

Yes No

Was it paid experience?

Yes No

Please describe the experience _____

Please describe your career goals _____

Additional Information

Are you currently in Foster Care?

Yes No

U.S. Military Service

Yes No

If yes, what branch? _____

Rank _____

Discharge _____

Dates _____

Have you ever been convicted of a crime?

Yes No

If yes, please describe and include dates and status of case _____

If yes, are you on probation?

Yes No

Name and phone number of officer _____

Are you on parole?

Yes No

Name and phone number of parole officer _____

Size pants _____

Size Shirt _____

Size Shoe _____

ENROLLMENT INTAKE FORM

Parent or Guardian

Last Name: _____ MI _____ First Name _____

Address/City/Zip: _____ Email Address: _____

No. in Household: _____ Telephone: _____ Date of Birth: ____/____/____

Household Type <input type="checkbox"/> Sgl. Parent-Female <input type="checkbox"/> Sgl. Parent-Male <input type="checkbox"/> Two-Parent <input type="checkbox"/> Foster Parent <input type="checkbox"/> Kinship Care <input type="checkbox"/> Teen Parent	Housing <input type="checkbox"/> Own <input type="checkbox"/> Rent <input type="checkbox"/> AMHA Housing <input type="checkbox"/> AMHA voucher for apt./ house <input type="checkbox"/> Homeless - do not have a home <input type="checkbox"/> Live w/Relatives or Friends	Race/Cultural Background <input type="checkbox"/> Black/African American <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Multiracial/Mixed <input type="checkbox"/> Amer. Indian/Alaskan Native <input type="checkbox"/> Middle Eastern <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Other	Education <input type="checkbox"/> Less than high school graduate <input type="checkbox"/> High school graduate or GED <input type="checkbox"/> Some college, Vocational school, or an Associate degree <input type="checkbox"/> Bachelor's or advanced degree	Health Insurance <input type="checkbox"/> Private <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> None Former Head Start Parent <input type="checkbox"/> Yes <input type="checkbox"/> No
Source of Income <input type="checkbox"/> Employed <input type="checkbox"/> Self-Employed <input type="checkbox"/> Unemployment <input type="checkbox"/> OWF <input type="checkbox"/> Soc. Security <input type="checkbox"/> SSI/SSD (Disability) <input type="checkbox"/> Child Support <input type="checkbox"/> No Income last 12 mos. <input type="checkbox"/> Other _____	Employment Status <input type="checkbox"/> Employed F/T <input type="checkbox"/> Employed P/T <input type="checkbox"/> Unemployed-in school <input type="checkbox"/> Unemployed-laid off <input type="checkbox"/> Unemployed-looking for work <input type="checkbox"/> Unemployed- NOT looking for work at this time <input type="checkbox"/> Retired	Occupation (Job Title) School or Training Program <input type="checkbox"/> Yes <input type="checkbox"/> No Title XX (child care sub.) <input type="checkbox"/> Yes <input type="checkbox"/> No	Food Stamps (SNAP) <input type="checkbox"/> Yes <input type="checkbox"/> No WIC <input type="checkbox"/> Yes <input type="checkbox"/> No Gender: F or M Disability: Y or N	Language Primary _____ Secondary _____

OTHER FAMILY MEMBERS (if more than 6 use additional sheet)

Category	2	3	4	5	6
Last Name					
First Name					
Birthdate					
Gender (circle one)	M or F				
Disability (circle one)	Y or N				
Race					
Education					
Health Insurance					
Source of Income					

I hereby affirm that the information provided on this application is true and complete to the best of my knowledge. I also understand that any false information or significant omissions may disqualify me from consideration for enrollment and/or may be considered just and sufficient cause for dismissal from the Head Start Program if discovered at a later date.

PARENT'S SIGNATURE/DATE

VERIFYING STAFF MEMBER/DATE

3) FAMILY SPECIAL FACTORS

- | | | |
|--|---|---|
| <input type="checkbox"/> Child Protective Services involvement | <input type="checkbox"/> Family history of domestic violence | <input type="checkbox"/> Family history of special education or school dropout |
| <input type="checkbox"/> Family of history of substance abuse | <input type="checkbox"/> Recent change in parental status (past 6 months) military, death, separation/divorce | <input type="checkbox"/> Do you currently have 3 or more children between the ages of 0-5 living in the household |
| <input type="checkbox"/> No medical insurance | <input type="checkbox"/> Receiving mental/health counseling (adult or child) | <input type="checkbox"/> Long term chronic illness (child or adult) |
| <input type="checkbox"/> Incarcerated parent | <input type="checkbox"/> Previous Pre-mature birth | <input type="checkbox"/> Currently pregnant
Due date: |

<input type="checkbox"/> Other agency referral <i>(please indicate)</i>
<input type="checkbox"/> Other family crisis or special family need <i>(please indicate)</i>

4) Are you an employee of Akron Summit Community Action, Inc.?

- No
- Yes

If yes, which location? _____

Do you have an immediate family member employed by Akron Summit Community Action, Inc.?
(Immediate Family: Husband, Wife, Mother, Father, Sister, Brother, Son, Daughter, Grandparent, Mother-in-Law, Father-in-Law)

- No
- Yes

If yes, please indicate which family member(s) and position(s)



**HEAD START/EARLY HEAD START PROGRAM
PARENTAL AUTHORIZATION - RELEASE/EXCHANGE HEALTH INFORMATION**

Child's Name _____	Date of Birth _____
Address _____	Phone number _____
City, State, Zip Code _____	
Parent/Guardian Name _____	

I authorize **Akron Summit Community Action Head Start/Early Head Start program** to exchange information with my child's health providers (i.e. Physicians, Dentists, Eye Professional, Summit County Public Health District, and other medical providers as needed).

I understand that by signing this consent, I give permission for the release/exchange of any medical information needed to meet the requirements of the Head Start/Early Head Start Performance Standards (Well Child Exams; Dental Exams; Immunization Record, Screening results for vision, hearing, lead, hemoglobin/hematocrit; and any follow-ups related to medical and dental referrals and treatment).

I understand that signing this release is voluntary, consent remains in effect for one year from the date signed; and I may cancel/revoke this authorization at any time by submitting a written request to the Head Start Center where my child is attending.

Below I have provided the names and location of health care providers, with whom, information can be released and/or exchanged.

Physician:	Address:
Dentist:	Address:
Eye Care Professional:	Address:
Other: Summit County Health District	Address: 1100 Graham Rd. Circle, Stow, OH 44224
Other:	Address:
Other:	Address:

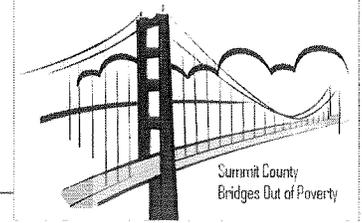
Signature of Parent/Guardian: _____ Date _____

FOR OFFICE STAFF

Signature of Staff (Witness) _____ Date _____

Distribution
Original: Child's File
Copy: Parent/Guardian

Summit County Bridges Out of Poverty
Getting Ahead : Pre-Workshop Assessment



Basic: _____

Name: _____ Date: _____

Address: _____ City: _____ Zip code: _____ Birthday: _____

Phone #: _____ Phone #: _____ Time in residence: _____

in house: _____

of kids: _____ (Please specify ages) _____

Emergency Contact Information:

Name: _____ Relationship: _____

Address: _____ Phone: _____

Employment:

Currently Working? _____ Place of Employment _____ Length _____

Job History? _____

Job Skills: _____

Have you ever been convicted of a Felony/Misdemeanor? _____ How many ? _____

Nature of offense: _____

Date of offense: _____

Eligibility for expungement? Yes _____ No _____ Not Sure _____

Are you currently involved in any type of court proceedings at this time? Yes _____ No _____

(if so will these court proceedings interfere with completing Getting Ahead Classes)

Do you currently have any health issues or concerns ? Yes _____ No _____ Type: _____

Do you currently have healthcare coverage? Yes _____ No _____

Mental Health/Addictions

Mental Health Diagnosis? Y N _____ When diagnosed? _____

Current Counseling/Services? _____ Medication? Y N _____

Past addictions? _____

Any current drug use? Y N Frequency _____ Current Treatment?

Any current alcohol use? Y N Frequency _____ Current Treatment?

Reflection Questions:

1. List 1-3 of your biggest problems or obstacles right now?

a. _____

b. _____

c. _____

Have you ever been involved in any other program, which required you to attend multiple sessions? Yes _____ No _____

If so did you complete the program and what was the outcome:

Getting Ahead Expectations

TELL ME ABOUT YOU! WHAT MAKES YOU WHO YOU ARE:

SPIRITUAL/FAITH

HOW WOULD YOUR FRIENDS AND FAMILY DESCRIBE YOU?

WHY ARE YOU HERE? WHY GETTING AHEAD? WHAT ARE YOUR EXPECTATIONS?

WHAT ARE SOME THINGS YOU WOULD LIKE TO WORK ON?

Name: _____

Getting Ahead/Circles Full-Assessment

1. Today's date is: _____ / _____ / _____
Month Day Year

2. This is a: ¹ Pre-Getting Ahead Assessment
³ 6-month (6-mos from start of GA)) Circles? ¹ Yes ² No) Big Group? ¹ Yes ² No
⁴ 12-month (12-mos from start of GA)) Circles? ¹ Yes ² No) Big Group? ¹ Yes ² No
⁵ 18-month (18-mos from start of GA)) Circles? ¹ Yes ² No) Big Group? ¹ Yes ² No
⁶ 24-month (24-mos from start of GA)) Circles? ¹ Yes ² No) Big Group? ¹ Yes ² No

3. \$_____ monthly wages (Circle Leader / GA investigator only) before taxes or withholding (gross)

4. Income, benefits, assets, and debt: include information for all members of the household.

Income	<u>Monthly Amount</u>
a. Wage and salary income	\$ _____
b. Other earned income	\$ _____
c. Child support received	\$ _____
d. Supplemental Security Income (SSI)	\$ _____
e. Military Pensions or VA Benefits	\$ _____
Benefits	<u>Monthly Amount</u>
f. Food Stamps	\$ _____
g. Public cash assistance	\$ _____
h. Unemployment benefits	\$ _____
i. Other public benefits	\$ _____
Educational Benefits	<u>Monthly Amount</u>
j. Pell Grant (Pro-rated by month)	\$ _____
k. Student Loan (as income source)	\$ _____
l. Military Veteran's Educational Award	\$ _____
Assets	<u>Total Amount</u>
m. Checking account(s) balance	\$ _____
n. Savings account(s) balance	\$ _____
o. Other investments, home ownership or account(s) balance	\$ _____
p. Individual Development Account	\$ _____
Debt	<u>Total Amount</u>
q. Back rent/mortgage owed	\$ _____
r. Overdue utility or other bills	\$ _____
s. Overdue credit card balance(s)	\$ _____
t. Unpaid medical bills	\$ _____
u. Student loans	\$ _____
v. Other debt (indicate type: _____)	\$ _____
w. Wages garnished	\$ _____
x. Child support owed	\$ _____

6. Household expenses: include information for all members of the household.

Expenses	Total Amount
a. Housing (mortgage/rent) and utilities	\$ _____
b. Food (groceries and food purchased away from home)	\$ _____
c. Childcare/preschool	\$ _____
d. Transportation (bus fare and/or gasoline)	\$ _____
e. Health care (insurance premiums and out of pocket)	\$ _____
f. Other necessities	\$ _____
g. Taxes (amounts deducted from paycheck, if working)	\$ _____

7. What is the highest level of education you have completed? (**MARK ONLY THE HIGHEST LEVEL COMPLETED; ASK AS OPEN-END, RECORD ANSWER BELOW**)

- ¹ Less than high school graduate
- ² Graduated from high school
- ³ Completed GED
- ⁴ Some college or technical training, incomplete
- ⁵ Completed technical training (CNA, cosmetology, auto mechanics, etc)
- ⁶ Completed 2 year college degree
- ⁷ Completed 4 year college degree
- ⁸ Some graduate education (post Bachelor's)
- ⁹ Other _____

8. Are you **currently enrolled** in an educational or training program?

- ¹ Yes ² No → → (**GO TO QUESTION 11**)

- a. What are you studying? _____
- b. How long does the program last? _____ (Months)
- c. About how much have you completed? 25% 50% 75% 100%

9. What diploma, degree, or certificate will you receive when you complete the program? (**ASK AS OPEN-END, RECORD ANSWER BELOW**)

- ¹ GED or high school diploma
- ² Professional license
- ³ Certificate of completion – non-academic program
- ⁴ Certificate awarded by a college or trade school, for credits completed after high school
- ⁵ Diploma awarded by a college or trade school, for credits completed after high school
- ⁶ 2-year degree (AA, AS, Associate degree)
- ⁷ 4-year degree (BA, BS, Bachelor's degree)
- ⁸ Graduate degree
- ⁹ Program does not award a credential
- ¹⁰ Other _____

10. Have you completed an educational or training program in the last 6 months?

¹ Yes ² No → → (GO TO QUESTION 12)

a. What did you study?

b. What diploma, degree, or certificate did you receive when you completed the program?
(ASK AS OPEN-END, RECORD ANSWER BELOW)

- ¹ GED or high school diploma
- ² Professional license
- ³ Certificate of completion – non-academic program
- ⁴ Certificate awarded by a college or trade school, for credits completed after high school
- ⁵ Diploma awarded by a college or trade school, for credits completed after high school
- ⁶ 2-year degree (AA, AS, Associate degree)
- ⁷ 4-year degree (BA, BS, Bachelor's degree)
- ⁸ Graduate degree
- ⁹ Program does not award a credential
- ¹⁰ Other _____

11. How many hours do you work in an average week? (ASK AS OPEN-END, RECORD ANSWER BELOW)

- ¹ Unemployed or 0 hours
- ² Working less than 15 hrs/week
- ³ Working 15 – 19 hrs/week
- ⁴ Working 20 – 24 hrs/week
- ⁵ Working 25 – 29 hrs/week
- ⁶ Working 30 – 34 hrs/week
- ⁷ Working 35 – 40 hrs/week
- ⁸ Working more than 40 hrs/week
- ⁹ Unable to work due to a temporary disability
- ¹⁰ Unable to work due to a permanent disability
- ¹¹ Unable to work (reason: _____)
- ¹² Retired
- ¹³ Other: _____

12. Do you currently have a child support order in place? (ASK AS OPEN-END, RECORD ANSWER BELOW)

- ¹ Yes (how many orders/children? _____)
 - ¹ yes, but I don't receive any payments
 - ² yes, but I only receive payments sometimes or irregularly in amount and frequency
 - ³ yes, and I always receive the full amount of income ordered
- ² No/Not eligible/Not applicable

13. As of today, do you have...

- a. ...your own vehicle? ¹ Yes ² No ³ NA
 - i. If no, how do you get where you need to go? _____
- b. ...a currently valid driver's license? ¹ Yes ² No ³ NA
- c. ...automobile insurance? ¹ Yes ² No ³ NA

14. As of today, do you have health insurance **for yourself**?

¹ Yes ² No

[IF YES TO Q. 14]

14a. What type of insurance?

- ¹ Private insurance only (job-based, COBRA, or private-pay)
- ² Both public and private insurance
- ³ Public insurance/Medicaid/Medicare only

15. How many children age 5 or younger are in your household? _____ (Number of children 5 or younger)

16. How many children 6-17 are in your household? _____ (Number of children 6-17)

(NOTE: If no children 17 or younger in the household, go to question 18)

17. How many of your minor children who live with you have health insurance?

- ¹ All children have health insurance
- ² Some children have health insurance and some children do not
- ³ None of the children have health insurance

[IF "All" or "Some" TO Q. 17]

17a. What type of insurance?

- ¹ Private insurance only (job-based, COBRA, or private-pay)
- ² Both public and private insurance
- ³ Public insurance/Medicaid/Medicare only

18. During the past 6 months have you...

- | | Yes | No | NA |
|--|---------------------------------------|--|---------------------------------------|
| a. Donated food, clothing, or other goods to an individual or organization? | <input type="checkbox"/> ¹ | <input type="checkbox"/> ² | <input type="checkbox"/> ³ |
| b. Been involved as a volunteer with a committee, taskforce, social action group, church, or community organization? | <input type="checkbox"/> ¹ | <input type="checkbox"/> ² | <input type="checkbox"/> ³ |
| How many hours? | | | |
| <input type="checkbox"/> ¹ Less than 5 hours/month | | <input type="checkbox"/> ³ 10-20 hours/month | |
| <input type="checkbox"/> ² 5-10 hours/month | | <input type="checkbox"/> ⁴ 20 or more hours/month | |
| c. Received food, clothing, or other donated goods? | <input type="checkbox"/> ¹ | <input type="checkbox"/> ² | <input type="checkbox"/> ³ |
| d. Obtained a car? | <input type="checkbox"/> ¹ | <input type="checkbox"/> ² | <input type="checkbox"/> ³ |
| e. Obtained a better paying job? | <input type="checkbox"/> ¹ | <input type="checkbox"/> ² | <input type="checkbox"/> ³ |
| f. Paid off a credit card bill or pay day loan? | <input type="checkbox"/> ¹ | <input type="checkbox"/> ² | <input type="checkbox"/> ³ |
| g. Opened or added money to a savings account? | <input type="checkbox"/> ¹ | <input type="checkbox"/> ² | <input type="checkbox"/> ³ |
| h. Examined your credit score? | <input type="checkbox"/> ¹ | <input type="checkbox"/> ² | <input type="checkbox"/> ³ |

IF YES: What was your credit score when you examined it? _____

19. As of right now, what are the three most important personal goals you want to accomplish in the next **6 months**?

20. What important personal goals have you accomplished during the **last 6 months**?

[SKIP IF THIS IS A Pre-Getting Ahead Assessment]

21. Please tell us which of the following best describes where you are in terms of your...

Finances	<input type="checkbox"/> ¹ I do not have enough income to purchase needed good and services	<input type="checkbox"/> ² I have some, but not enough income to purchase needed goods and services- and to save money	<input type="checkbox"/> ³ I have enough income to purchase needed goods and services- and to have money saved for crises	<input type="checkbox"/> ⁴ I have enough income to purchase needed goods and services, to save for emergencies, and to invest for future	<input type="checkbox"/> ⁵ I actively seek to increase personal financial assets over time and help build community assets.
Emotions	<input type="checkbox"/> ¹ I cannot choose and control emotional responses, and I often behave in ways that are harmful to myself and others	<input type="checkbox"/> ² I can sometimes choose and control my emotional responses, and sometimes behave in ways that are harmful to myself or others	<input type="checkbox"/> ³ I can almost always choose and control my emotional responses, and I almost never behave in ways that are harmful to myself or others	<input type="checkbox"/> ⁴ I am good at choosing and controlling my emotional responses and I engage in positive behaviors toward others	<input type="checkbox"/> ⁵ I actively seek to improve emotional health in myself and others
Mental Capacity	<input type="checkbox"/> ¹ I lack the ability, education, or skills to compete for well-paying jobs	<input type="checkbox"/> ² I have some ability, education, or skills to compete for well-paying jobs	<input type="checkbox"/> ³ I have enough ability, education, or skills to compete for well-paying jobs	<input type="checkbox"/> ⁴ I have plenty of ability, education, or skills to compete for well-paying jobs	<input type="checkbox"/> ⁵ I actively seek to improve on existing ability, education, or skills- and build mental resources in community
Language Skills	<input type="checkbox"/> ¹ I lack the vocabulary, language ability, and negotiation skills needed for workplace settings	<input type="checkbox"/> ² I have some of the vocabulary, language ability, and negotiation skills needed for workplace settings	<input type="checkbox"/> ³ I have enough vocabulary, language ability and negotiation skills needed for workplace settings.	<input type="checkbox"/> ⁴ I have plenty of vocabulary, language ability and negotiation skills needed for workplace settings.	<input type="checkbox"/> ⁵ I actively seek to improve upon already strong vocabulary and language ability foundation- and work to develop language resources in community.
Social Support	<input type="checkbox"/> ¹ I lack positive friends, family and connections that can be accessed to improve resources	<input type="checkbox"/> ² I have some positive friends, family and connections that can be accessed to improve resources	<input type="checkbox"/> ³ I have enough positive friends, family and connections that can be accessed to improve resources	<input type="checkbox"/> ⁴ I have plenty of positive friends, family and connections that can be accessed to improve resources	<input type="checkbox"/> ⁵ I actively develop networks and social resources that can be accessed to improve personal and community resources
Physical Health	<input type="checkbox"/> ¹ I lack physical health and mobility for workplace settings.	<input type="checkbox"/> ² I have some physical health and mobility problems that could limit effectiveness in workplace.	<input type="checkbox"/> ³ I have physical health and mobility needed for workplace settings.	<input type="checkbox"/> ⁴ I consistently maintain physical health and mobility needed for self and others in workplace.	<input type="checkbox"/> ⁵ I actively develop physical resources or self, workplace, and community.

Spiritual Health	<input type="checkbox"/> ¹ I lack cultural connections or sense of spiritual purpose that offers support and guidance	<input type="checkbox"/> ² I have some cultural connections or sense of spiritual purpose that offers support and guidance	<input type="checkbox"/> ³ I have sufficient cultural connections or sense of spiritual purpose that offers support and guidance	<input type="checkbox"/> ⁴ I have plenty of cultural connections or sense of spiritual purpose that offers support and guidance	<input type="checkbox"/> ⁵ I actively seek cultural connections and/or spiritual growth
Integrity and Trust	<input type="checkbox"/> ¹ I cannot be trusted to keep my word, to accomplish tasks, and to obey laws even when under supervision	<input type="checkbox"/> ² I can sometimes be trusted to keep my word, to accomplish tasks, and to obey laws when under supervision	<input type="checkbox"/> ³ I can be trusted to keep my word, to accomplish tasks, and to obey laws without supervision	<input type="checkbox"/> ⁴ I can invariably be trusted to keep my word, to accomplish tasks, to obey laws, and to inspire others to do the same	<input type="checkbox"/> ⁵ I actively seek to build integrity and trust- and I set high ethical standards at work and in community.
Motivation and Persistence	<input type="checkbox"/> ¹ I lack energy or drive to prepare for, plan, and complete projects, jobs, and personal change.	<input type="checkbox"/> ² I have some energy or drive to prepare for, plan, and complete projects, jobs, and personal change.	<input type="checkbox"/> ³ I have enough energy or drive to prepare for, plan, and complete projects, jobs, and personal change.	<input type="checkbox"/> ⁴ I have plenty of energy or drive to prepare for, plan, and complete projects, jobs, and personal change.	<input type="checkbox"/> ⁵ I actively seek to maintain motivation and persistence- and to assist others in finding theirs.
Relationships/ Role Models	<input type="checkbox"/> ¹ I lack access to others who are safe, supportive, and nurturing	<input type="checkbox"/> ² I have limited access to others who are safe, supportive, and nurturing	<input type="checkbox"/> ³ I have enough access to others who are safe, supportive, and nurturing	<input type="checkbox"/> ⁴ I have plenty of access to others who are safe, supportive, and nurturing	<input type="checkbox"/> ⁵ I actively seek out others who are safe, supportive, and nurturing- and I am safe, supportive and nurturing of others
Knowledge of Hidden Rules	<input type="checkbox"/> ¹ I lack knowledge of hidden rules of other economic classes.	<input type="checkbox"/> ² I have some awareness of hidden rules of other economic classes but I cannot use them.	<input type="checkbox"/> ³ I know the rules of other economic classes and can use some of them in personal ways.	<input type="checkbox"/> ⁴ I know the rule of all three economic classes and can use most of them effectively in limited settings.	<input type="checkbox"/> ⁵ I actively seek to understand the rules of all three economic classes- and to use them effectively in a variety of settings.

21. Please tell me how old you were on your last birthday: _____

22. What is your racial or ethnic background? (ASK AS OPEN-END, RECORD ANSWER BELOW)

- ¹ Black/African American
- ² American Indian or Alaska Native
- ³ Asian or Pacific Islander
- ⁴ White or Caucasian
- ⁵ Hispanic, Latino or Chicano
- ⁶ Other (Please describe: _____)

23. What is your marital status? (ASK AS OPEN-END, RECORD ANSWER BELOW)

- ¹ Single, never married
- ² Married
- ³ Living with significant other
- ⁴ Divorced
- ⁵ Widowed
- ⁶ Separated
- ⁷ Other: _____
- ⁹ Don't know / Refused to answer / Not applicable

24. Gender (RECORD BY DIRECT OBSERVATION IF POSSIBLE)

- ¹ Male
- ² Female

SCDJFS/CSEA Client Referral Forms

DATE: _____ CLIENT NAME: _____

ADDRESS: _____

TELEPHONE #: _____

CSEA SETS #: _____

CRIMINAL CASE #: _____

BIRTH DATE: _____ SSN: _____

Duration of Nonsupport and Time Served? _____

Amount of Arrears: _____ Monthly Obligation: _____

CSEA Officer: _____

Comments: _____

Prosecutor or Probation officer signature _____

2013-2014 FREE AND REDUCED PRICE SCHOOL MEALS FAMILY APPLICATION

Part 1. ALL HOUSEHOLD MEMBERS

Names of <u>all</u> household members (First, Middle Initial, Last)	Name of school and school grade level for each child/or indicate "NA" if child is not in school.		Check if a foster child (legal responsibility of welfare agency or court). *If all children listed below are foster children, skip to Part 5 to sign this form.	Check if No Income
	School	Grade		
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>

Part 2. BENEFITS: If any member of your household receives SNAP or OWF benefits, provide the name and 10-digit case number for the person who receives benefits and **skip to Part 5**. If no one receives these benefits, **skip to Part 3**.

NAME: _____ 10-DIGIT CASE NUMBER: _____

Part 3. If any child you are applying for is homeless, migrant, or a runaway check the appropriate box and call [your school, homeless liaison, migrant coordinator at phone #] Homeless Migrant Runaway

Part 4. TOTAL HOUSEHOLD GROSS INCOME (before deductions). List all income on the same line as the person who receives it. Check the box for how often it is received. Record each income only once.

1. NAME (List all household members with income)	2. GROSS INCOME AND HOW OFTEN IT WAS RECEIVED												All Other Income (include frequency, such as "weekly" "monthly" "quarterly" "annually")			
	Earnings from work before deductions	Weekly	Every 2 Weeks	Twice Monthly	Monthly	Welfare, child support, alimony	Weekly	Every 2 Weeks	Twice Monthly	Monthly	Pensions, retirement, Social Security, SSI, VA benefits	Weekly		Every 2 Weeks	Twice Monthly	Monthly
<i>(Example) Jane Smith</i>	\$200	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$150	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$0	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$50 / quarterly
\$		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ / _____
\$		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ / _____
\$		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ / _____
\$		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ / _____

Part 5. SIGNATURE AND LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER (ADULT MUST SIGN)
An adult household member must sign the application. If Part 4 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box. (See Privacy Act Statement on the back of this page.)

I certify (promise) that all information on this application is true and that all income is reported. I understand that the school will get Federal funds based on the information I give. I understand that school officials may verify (check) the information. I understand that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted.

Sign here: X _____ Print name: _____ Date: _____

Address: _____ Phone Number: _____

Last four digits of your Social Security Number: _____ I do not have a Social Security Number

Part 6. Children's ethnic and racial identities (optional)

Choose one ethnicity:

- Hispanic/Latino
 Not Hispanic/Latino

Choose one or more (regardless of ethnicity):

- Asian American Indian or Alaska Native Black or African American
 White Native Hawaiian or other Pacific Islander

Don't fill out this part. This is for school use only.

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24 Monthly x 12

Total Income: _____ Per: Week, Every 2 Weeks, Twice A Month, Month, Year Household size: _____

Categorical Eligibility: _____ Date Withdrawn: _____ Eligibility: Free ___ Reduced ___ Denied ___ Reason: _____

Determining/Approval Official's Signature: _____ Date: _____

Confirming Official's Signature: _____ Date: _____

Follow-up Official's Signature: _____ Date: _____

If selected for Verification, Date Verification Notice Sent: _____ Response Date: _____ 2nd Notice Sent: _____ Results Sent: _____

Verification Result: No Change Free to Reduced Price Free to Paid Reduced Price to Free Reduced Price to Paid

Your children may qualify for free or reduced price meals if your household income falls at or below the limits on this chart:

INCOME ELIGIBILITY GUIDELINES			
Household size	Yearly	Monthly	Weekly
1	21,257	1,772	409
2	28,694	2,392	552
3	36,131	3,011	695
4	43,568	3,631	838
5	51,005	4,251	981
6	58,442	4,871	1,124
7	65,879	5,490	1,267
8	73,316	6,110	1,410
Each additional person:	7,437	620	144

Privacy Act Statement: This explains how we will use the information you give us.

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced price meals. You must include the social security number of the adult household member who signs the application. The social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Ohio Works First (OWF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the lunch and breakfast programs. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly. "In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer".

National School Lunch Program/ Prototype Notification Letter
(Put on Sponsor Letterhead)

NOTICE TO HOUSEHOLDS OF APPROVAL/DENIAL OF BENEFITS
For the 2013-2014 Program Year

Dear Parent/Guardian:

You applied for free or reduced-meals for the following child(ren):

Your application was:

Approved for free meals.

Approved for reduced-price meals at \$_____ for lunch, \$_____ for breakfast, and \$_____ for snacks.

Denied for the following reason(s):

Income over the allowable amount.

Incomplete application because _____

Other _____

If you do not agree with the decision, you may discuss it with the [School official's name] at [phone number].

If you wish to review the decision further, you have a right to a fair hearing. This can be done by calling or writing the following official:

Name **(School Hearing Official's name)** _____

Address _____

Phone _____

If you are not eligible now but have a decrease in household income, become unemployed, have an increase in household size or become eligible to receive Food Assistance Program (SNAP) or OWF funds, fill out an application at that time.

Sincerely,
[signature]

Name

Title

Date

ENERGY ASSISTANCE PROGRAMS APPLICATION 2012–2013

The Ohio Department of Development (ODOD) offers several programs to help low-income Ohioans pay their utility bills and improve the energy efficiency of their homes. With this form, you may apply for the Home Energy Assistance Program (HEAP), the Percentage of Income Payment Plan Plus (PIPP Plus), and the Home Weatherization Assistance Program (HWAP). For the Winter Crisis Program (WCP) and the Summer Crisis Program (SCP), the utility bill must be in the name of an eligible household member, and an appointment is required at a local provider agency.

ELIGIBILITY

HEAP is a federally funded program designed to assist eligible low-income Ohioans with their winter heating bills. Households may be eligible for assistance from HEAP, WCP, SCP, or HWAP if the household income is at or below 200 percent of the federal poverty guidelines. Households may be eligible for assistance from PIPP Plus if the household income is at or below 150 percent of the federal poverty guidelines. Once your application has been processed, you will receive a notification letter telling you whether or not you are eligible for bill payment assistance. If you are eligible, the amount of your benefit will depend on federal funding levels, how many people live with you, total household income, and the primary fuel you use to heat your home. In most cases, benefits will be a credit applied to your energy bill by your utility company. This is a one-time benefit. If you are eligible for weatherization services, your application will be obtainable by the agency providing services in your area. The types of assistance you receive will be based on your home's energy efficiency. If you live in federally subsidized housing and have a utility bill in your name, you may be eligible for assistance.

Residents of any licensed medical facility (hospital, skilled nursing facility, or intermediate care facility) or publicly operated community residence (example: YMCA) are ineligible. Boarding/rooming houses, group homes, or emergency shelters are ineligible for payment assistance, but may be eligible for weatherization services. All persons who share a common kitchen or bath are considered members of the same household and must apply on one application. Depending on the volume of applications received, there may be a delay in processing your application.

PERCENTAGE OF INCOME PAYMENT PLAN PLUS (PIPP PLUS)

PIPP Plus is a special payment plan that requires eligible customers to pay a portion of their household income each month to maintain utility service. PIPP Plus protects customers from disconnection of service, as long as they follow the program's rules about monthly payments. All gas and electric companies regulated by the Public Utilities Commission of Ohio (PUCO) must offer this plan to their customers. PIPP Plus is not available to customers of rural electric co-ops, municipal utilities, or users of delivered fuels. The utility bill must be in the name of the PIPP Plus applicant. The first PIPP Plus installment must be paid upon enrollment in order to receive the arrearage credit.

PIPP Plus enrollment can occur through this application only for the following companies: American Electric Power (AEP), Columbia Gas, Dayton Power and Light (DP&L), Dominion East Ohio Gas, Duke Energy, FirstEnergy (Cleveland Illuminating Co., Ohio Edison, Toledo Edison), and Vectren.

HOME WEATHERIZATION ASSISTANCE PROGRAM (HWAP)

HWAP is a federally-funded, low-income residential energy efficiency program that reduces the energy use of qualified households throughout the state. HWAP services include attic, wall, and basement insulation; blower door guided air leakage reduction; heating system repairs or replacements; electric baseload measures that address lighting and appliance efficiency; and health and safety inspections and testing. Services are based on the structure and energy use of the home. HWAP is administered locally by community action, social service, and local government agencies.

CONTACT INFORMATION

For questions regarding Energy Assistance Programs or to check the status of your HEAP application:

energyhelp.ohio.gov or e-mail us at energyhelp@development.ohio.gov
1-800-282-0880 or 614-644-6600 for Franklin County residents.

For the hearing impaired only:

1-800-686-1557 or 614-752-8808 for Franklin County residents.

INCOME DEFINITION

Household income is defined as the gross income of all household members, except wage or salary income earned by dependent minors under 18 years of age. Heads of household and spouses may never be considered as minors. Gross income includes, but is not limited to, wages (excluding documented health insurance premiums), interest, annuities, pensions, Social Security (excluding Medicare premiums), retirement, employment disability, public assistance, Supplemental Security Income (SSI), alimony, child support, unemployment benefits, Workers' Compensation, and any other indirect income such as utility allowances. Other exclusions may apply if documented.

Please visit energyhelp.ohio.gov for a list of all included and excluded income.

2012-2013 Income Guidelines

Size of Household	Total Gross Annual Household Income	
1	up to \$ 16,755	\$22,340
2	up to \$ 22,695	\$30,260
3	up to \$ 28,635	\$38,180
4	(150%) up to \$ 34,575	(200%) \$46,100
5	(For PIPP Plus) up to \$ 40,515	(For HEAP and HWAP) \$54,020
6	up to \$ 46,455	\$61,940
7	up to \$ 52,395	\$69,860
8	up to \$ 58,335	\$77,780

For households with more than 8 members, add \$5,940 for 150% and \$7,920 for 200% per member.

INSTRUCTIONS (PLEASE READ)

You must provide proof of income for everyone living in your household. Examples of documents that provide proof of income are: payroll stubs, statements from employers, public assistance payment histories, or benefit letters from Social Security, Workers' Compensation, Unemployment Compensation, tax forms/schedule, etc. Please provide income documentation to support your response to question #5. If you are missing documentation for any income source or you list "0" income, please explain. If your response to question #7 is "No Income," a written, signed statement which provides an explanation as to how you are maintaining your household must be submitted. **Failure to provide the required documents will delay the processing of your application. Please send copies, as originals will not be returned.**

If anyone in your household is disabled, you may be eligible for a larger benefit. To be eligible for this benefit, you must submit proof of disability, but need not disclose the nature of the disability. Proof includes a doctor's statement, benefits letters for Supplemental Security Income, Social Security Disability, Workers' Compensation, etc. "Disabled" describes a person who has some impairment in body or mind that makes the person unfit to work at any substantial employment that the person would otherwise reasonably be able to perform and that will, with reasonable probability, continue for an indefinite period of at least 12 months without any present indication of recovery therefrom, or who has been certified as permanently and totally disabled by a state or federal agency having the function of so classifying persons. Households which have a member who is age 60 or older will also be evaluated for an increased benefit.

Please provide proof of citizenship or alien status for all household members. **Proof of citizenship or alien status is required for the primary applicant.** If you are a United States citizen by birth, the verification you provide to show your age (birth certificate, baptismal record, U.S. passport) will also provide verification of your citizenship status. However, if those documents were not used for proof of age or if you were born outside of the United States, are a naturalized citizen or an alien, you will need to provide one of the following items: 1) Naturalization Papers/Certifications of citizenship (INS Form I-179, INS Form I-197), 2) Permanent Visa, 3) Birth Certificate/Hospital Birth Records, 4) Refugee Registration Cards, 5) U.S. Passport, 6) INS ID Card, 7) Baptismal Record (Only when place and date of birth is shown.), 8) Military Service Records, 9) Indian Census Records, 10) Voter Registration Cards, 11) Signed statement from a U.S. citizen which declares under penalties of perjury that individual in question is a U.S. citizen, 12) Alien Registration Cards/Re-entry permits, 13) INS Form I-151 or I-551 (Form I-151 will not be valid after August 1, 1993.), 14) INS Form I-94 if annotated with either: a) Sections 203(a)(7), 207, 208, 212(d)(5), 243(h), or 241(b)(3) of the Immigration and Nationality Act; or b) One or a combination of the following terms: Refugee, Parolee, or Asylee, 15) INS Form G-641, "Application for verification of Information from INS Records", when annotated at bottom by INS representative as lawful admission for humanitarian reasons, 16) Documentation that alien is classified pursuant to Sections: 101(a)(2), 203(a), 204(a)(1)(a), 207, 208, 212(d)(5), 241(b)(3), 243(h), or 244(a)(3), of the Immigration and Nationality Act, 17) Court order stating that deportation has been withheld pursuant to Section 241(b)(3) or 243(h) or of the Immigration and Nationality Act, 18) INS Form I-688, or 19) Verified citizenship for OWF Program.

Copies of all heating and electric bills are required in order to process your application. If your main heating bill is not in an eligible household member's name, your benefit may be sent to your electric company.

PRIVACY ACT NOTICE

DISCLOSURE: The disclosure of social security numbers is mandatory to receive HEAP benefits. **AUTHORITY:** 45 CFR 96.84 (c); 42 U.S.C. 405(c)(2)(C)(i) **USE:** The state will use social security numbers in the administration of the HEAP to verify information supplied on the application, to prevent, detect, and correct fraud, waste, and abuse, and for the purpose of responding to requests for information from agency programs funded by block grants to states for temporary assistance for needy families or agencies requesting information for child support or to establish paternity. The applicant may be held civilly or criminally liable under federal or state law for knowingly making false or fraudulent statements.

The State of Ohio is an Equal Opportunity Employer and Provider of ADA Services.

**PLEASE SIGN AND MAIL APPLICATION TO: OFFICE OF COMMUNITY ASSISTANCE
HOME ENERGY ASSISTANCE PROGRAM
P.O. BOX 1240, COLUMBUS, OHIO 43216**

8) What is your **main** source of heat? (Check only one)

- Natural Gas
 Bottle Gas or Propane (L.P. Gas)
 Fuel oil or Kerosene
 Coal, Wood or Pellets
 Electric
 Other _____

Complete this section for your main heating source, including all-electric homes. Give your heating company name and account number below. Include a copy of your most recent fuel or heating bill from your current address.	Complete the section below with your electric company name and account number. Include a copy of your most recent electric bill from your current address.
Main Heating Source (Same source as Question 8.) <input type="checkbox"/> <small>yes</small> <input type="checkbox"/> <small>no</small> If you are not currently enrolled in PIPP Plus, do you want to enroll? (Please see front page for PIPP Plus description) <input type="checkbox"/> <small>yes</small> <input type="checkbox"/> <small>no</small> If you are currently enrolled in PIPP Plus, would you like to reverify your household income for eligibility? Company/Vendor <input style="width:100%;" type="text"/> Account # <input style="width:100%;" type="text"/> 9) <input type="checkbox"/> <small>yes</small> <input type="checkbox"/> <small>no</small> Are your heating costs included in your rent? 10) <input type="checkbox"/> <small>yes</small> <input type="checkbox"/> <small>no</small> Is the name on your heating bill different from the Applicant's name? If yes, give that name. First: <input style="width:50%;" type="text"/> Last: <input style="width:50%;" type="text"/> 11) <input type="checkbox"/> <small>yes</small> <input type="checkbox"/> <small>no</small> Do you share a main heating source meter with another household?	Electric <input type="checkbox"/> <small>yes</small> <input type="checkbox"/> <small>no</small> If you are not currently enrolled in PIPP Plus, do you want to enroll? (Please see front page for PIPP Plus description) <input type="checkbox"/> <small>yes</small> <input type="checkbox"/> <small>no</small> If you are currently enrolled in PIPP Plus, would you like to reverify your household income for eligibility? Company/Vendor <input style="width:100%;" type="text"/> Account # <input style="width:100%;" type="text"/> 12) <input type="checkbox"/> <small>yes</small> <input type="checkbox"/> <small>no</small> Is your electricity included in your rent? 13) <input type="checkbox"/> <small>yes</small> <input type="checkbox"/> <small>no</small> Is the name on your electric bill different from the Applicant's name? If yes, give that name. First: <input style="width:50%;" type="text"/> Last: <input style="width:50%;" type="text"/> 14) <input type="checkbox"/> <small>yes</small> <input type="checkbox"/> <small>no</small> Do you share an electric meter with another household?

15) Do you rent or own your home? Rent Own (Buying) skip to question 19.

16) Landlord's Name
 Address
 Telephone Number

- 17) yes no Do you rent a room in someone else's home? If yes, please list all household member information under question number 4.
- 18) yes no Do you receive **rental** assistance from the government (i.e. Section 8, HUD, Metropolitan Housing)?
- 19) yes no Has your household received weatherization services from any other program; (for example, a utility program)?
 If yes, which program?
- 20) yes no Would you like to apply for the Home Weatherization Assistance Program (HWAP)?
 If yes, please check the energyhelp.ohio.gov website for a list of providers in your area.
- 21) yes no I am enrolled in or eligible for Medicare. I consent to the release of my name, address, phone number, and social security number to my local Area Agency on Aging, or the Ohio State Health Insurance Information Program (OSHIP), or their designee, for help in applying for prescription drug assistance and other benefits.
- 22) Number of Native Americans in the household (as defined by the U.S. Bureau of Indian Affairs).

I authorize the Tax Commissioner of the Ohio Department of Taxation or any agent designated by the Tax Commissioner of the Ohio Department of Taxation as well as the Director of the Ohio Department of Development or any designated employee of the Director, to disclose to the Director of the Ohio Department of Development or any designated employee of the Director, or to the Tax Commissioner of the Ohio Department of Taxation, or any agent or employee designated by the Tax Commissioner, all of my State of Ohio income tax information. **The applicant expressly waives notice of the disclosure(s).** The applicant expressly waives the confidentiality provisions of the Ohio Revised Code which would otherwise prohibit disclosure and agrees to hold both the Ohio Department of Taxation and the Ohio Department of Development and its agents and employees harmless with respect to the limited disclosure herein. This authorization is to be liberally construed and interpreted; any ambiguity shall be resolved in favor of the Tax Commissioner of the Ohio Department of Taxation and/or the Director of the Department of Development. This authorization shall be irrevocable for a period of three years from the date that the application is signed, and is binding on any and all heirs, beneficiaries, survivors, assigns, executors, administrators, successors, receivers, trustees, or other beneficiaries.

I understand that by signing this application, I grant the Ohio Department of Development or its authorized providers access to my bank, employment, public assistance, utility company, or other records needed for verification and evaluation of services. By signing this application, I give the Ohio Department of Development, its designees and authorized providers, and the U.S. Department of Energy and its designees and authorized providers, the right to inspect my home and any work performed on my home. I understand that filling out this application does not guarantee that my household will receive assistance. I understand that any authorized provider may rescind an approved payment if information is acquired which determines that my household is not eligible for services according to the rules of each program. I understand that I have the right to appeal within 30 days of a written determination of services or assistance. I also understand that I have the right to request a state hearing within 90 days of a written determination. I certify that the information I have provided in this application is, to the best of my knowledge, a true, accurate and complete disclosure of the requested information. I understand that I may be held civilly and criminally liable under federal and state laws for knowingly making false or fraudulent statements. If I am or become a PIPP customer I understand that I may be included in a group for which electric service is purchased in common. The disclosure of social security numbers is mandatory to receive energy assistance benefits (45CFR 96.84(c); 42 U.S.C. 405(c)(2)(C)(i)).

X Sign Here _____ **Application Date** _____

NAZARETH HOUSING DEVELOPMENT CORPORATION

795 Russell Avenue Akron, OH 44307

Phone: (330) 374-1526 | Fax: 330-374-1569 | www.nazarethhousing.org

PRELIMINARY APPLICATION FOR AFFORDABLE HOUSING



PARTICIPANT INFORMATION

	PRIMARY APPLICANT	CO-APPLICANT
NAME:		
ADDRESS:		
CITY, STATE, ZIP:		
PRIMARY PHONE #:		
OTHER PHONE #:		
EMAIL ADDRESS:		

HOUSEHOLD INFORMATION

PLEASE LIST ALL MEMBERS OF YOUR HOUSEHOLD (INCLUDING YOURSELF):

	NAME	RELATIONSHIP	DATE OF BIRTH	ADULT OR CHILD
1				
2				
3				
4				
5				

EMPLOYMENT INFORMATION

	PRIMARY APPLICANT	CO-APPLICANT
CURRENT EMPLOYER:		
LENGTH OF EMPLOYMENT:		
TYPE OF EMPLOYMENT:	FULL-TIME <input type="checkbox"/> PART-TIME <input type="checkbox"/>	FULL-TIME <input type="checkbox"/> PART-TIME <input type="checkbox"/>

- IF CURRENT EMPLOYMENT IS LESS THAN THREE YEARS, PLEASE PROVIDE THE SAME INFORMATION ON THE LAST PREVIOUS EMPLOYER BELOW.
- ADDITIONAL NOTE REGARDING EMPLOYMENT THAT YOU MAY WANT TO INCLUDE, SUCH AS YOUR EMPLOYMENT BEING SEASONAL, TEMPORARY, THAT YOU ARE A STUDENT, ETC.

INCOME AND EXPENSES INFORMATION

YOU MAY ATTACH ADDITIONAL SHEETS WITH EXPLANATIONS IF NECESSARY. OUR PROGRAM DOES NOT REQUIRE APPLICANTS TO HAVE PERFECT CREDIT.

DO YOU FOLLOW A HOUSEHOLD BUDGET? _____ DO YOU HAVE A SAVINGS ACCOUNT? _____
 LIST GROSS INCOME FOR ALL HOUSEHOLD MEMBERS, INCLUDING CHILD SUPPORT, SSD, SSI, UNEMPLOYMENT, TANF, AND SPOUSAL SUPPORT:

HOUSEHOLD MEMBER	SOURCE OF INCOME	GROSS MONTHLY AMOUNT

WHAT IS YOUR CURRENT RENT? _____ UTILITIES (TOTAL ESTIMATED) _____

CAR PAYMENT _____ OTHER LOANS _____

DO YOU HAVE STUDENT LOANS? _____ IF SO, HOW MUCH DO YOU PAY MONTHLY? _____

IF YOU HAVE ANY OTHER LOANS, PLEASE LIST THAT THEY ARE FOR AND HOW MUCH YOU OWE:

WHAT IS YOUR OUTSTANDING BALANCES ON CREDIT CARDS? _____

ARE YOU DELINQUENT ON ANY FEDERAL, STATE OR LOCAL TAXES? _____

DO YOU CURRENTLY HAVE ACCOUNTS IN COLLECTIONS? IF SO, HOW MUCH? _____

LIENS OR JUDGMENTS? HOW MUCH AND HOW LONG? _____

HAVE YOU EVER DECLARED BANKRUPTCY? (IF SO, PLEASE GIVE DATE) _____

HOW WOULD YOU RATE YOUR CREDIT HISTORY? _____

OTHER GENERAL INFORMATION

ARE YOU A FIRST TIME HOMEBUYER? _____ DO YOU CURRENTLY OWN PROPERTY? _____

HOW DID YOU HEAR ABOUT US? _____

HAVE YOU ATTENDED HOMEBUYER AND/OR FINANCIAL MANAGEMENT CLASSES? _____

IF YES, WHERE AND WHEN: _____

DO YOU HAVE A PREFERENCE OF WHERE YOU WANT TO LIVE? _____

ARE YOU INTERESTED IN: _____ HOMEOWNERSHIP | RENTAL | LEASE PURCHASE

HOW LONG DO YOU THINK IT SHOULD TAKE TO BE IN YOUR OWN HOME? _____

BY COMPLETING AND SIGNING THIS APPLICATION, I GIVE MY PERMISSION FOR NAZARETH TO DISCUSS AND OBTAIN MY FINANCIAL AND OTHER PERSONAL INFORMATION WITH THEIR PARTNER AGENCIES AND LENDERS. I ACKNOWLEDGE THAT ALL THE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

Signature of Applicant: _____ Date: _____

Signature of Co-Applicant: _____ Date: _____



COUNTY OF SUMMIT
 THE HIGH POINT OF OHIO
 RUSSELL M. PRY, EXECUTIVE



Central Intake Form

GENERAL CLIENT INFORMATION

Date of Application _____

Agreed to ROI Yes No

HMIS Client ID # _____

Applicant 1 Full Legal Name

Relation to HOH

Applicant 2 Full Legal Name

Relation to HOH

Social Security Number

Age

Date of Birth

Social Security Number

Age

Date of Birth

Does Applicant have a phone? Yes No

Applicant Phone Number

Alternate Contact Name

Alternate Contact Phone Number

Race: (optional - check all that apply)
 A1 A2
 Asian
 American Indian or Alaska Native
 Black or African American
 White
 Native Hawaiian/Other Pacific Islander

Gender:
 A1 A2
 Male
 Female
 Other _____

Marital Status:
 A1 A2
 Divorced
 Married
 Separated
 Single
 Widowed

Ethnicity: (optional - check one)
 A1 A2
 Hispanic
 Non-Hispanic/Other

Are you a Domestic Violence Victim/Survivor?
 A1 Yes No
 A2 Yes No

Are you currently pregnant?
 A1 Yes No
 A2 Yes No

If yes, when experience occurred?
 A1 A2
 Within the past 3 months
 3 to 6 months ago
 6 to 12 months ago
 More than a year ago

If yes, when are you due? _____

Are you a U.S. Military Veteran?
 A1 Yes No
 A2 Yes No

If yes for DV, are you currently fleeing?
 A1 Yes No
 A2 Yes No

Do you have a long-term disability? Yes* No

Please check Disabilities that apply to you: A1 A2
 (please check all that apply)
 A1 A2
 Physical Disability
 Developmental Disability
 Chronic Health Condition
 HIV/AIDS
 Mental Health
 Alcohol Abuse
 Drug Abuse
 Both Alcohol and Drug Abuse

Do you require handicap accessibility? A1 Yes No

A2 Yes No

FAMILY STATUS -- Household Type (skip if single adult):

- | | | |
|--------------------------|-----------------------|-----------------------|
| Female Single Parent | Two Parent Family | Grandparent and child |
| Male Single Parent | Couple w. no Children | Foster Parents |
| Non-custodial care giver | Other | |

How many children do you have? _____

HOUSING STATUS

Residence Prior to Program Entry?			
A1 A2		A1 A2	
<input type="checkbox"/> <input type="checkbox"/> Emergency Shelter*		<input type="checkbox"/> <input type="checkbox"/> Place not meant for habitation	
<input type="checkbox"/> <input type="checkbox"/> Transitional housing for homeless		<input type="checkbox"/> <input type="checkbox"/> Safe Haven	
<input type="checkbox"/> <input type="checkbox"/> Permanent housing for homeless		<input type="checkbox"/> <input type="checkbox"/> Staying/Living with Family	
<input type="checkbox"/> <input type="checkbox"/> Psychiatric Hospital or Facility*		<input type="checkbox"/> <input type="checkbox"/> Staying/Living with Friends	
<input type="checkbox"/> <input type="checkbox"/> Hospital(non-psychiatric)*		<input type="checkbox"/> <input type="checkbox"/> Rental by Client-No Subsidy	
<input type="checkbox"/> <input type="checkbox"/> Substance Abuse Facility*		<input type="checkbox"/> <input type="checkbox"/> Rental by Client-VASH	
<input type="checkbox"/> <input type="checkbox"/> Jail, Prison or Juvenile Facility*		<input type="checkbox"/> <input type="checkbox"/> Rental by Client-GPD TIP	
<input type="checkbox"/> <input type="checkbox"/> Hotel/Motel no emergency shelter subsidy		<input type="checkbox"/> <input type="checkbox"/> Rental by Client-Other Subsidy	
<input type="checkbox"/> <input type="checkbox"/> Foster care/group home		<input type="checkbox"/> <input type="checkbox"/> Owned by Client-No Subsidy	
<input type="checkbox"/> <input type="checkbox"/> Long Term Care Facility/Nursing Home		<input type="checkbox"/> <input type="checkbox"/> Owned by Client-With Subsidy	
<input type="checkbox"/> <input type="checkbox"/> Residential Project/Halfway House no homeless criteria		<input type="checkbox"/> <input type="checkbox"/> Other (please specify): _____	
Client entering from Streets, Emergency Shelter (ES) or Safe Haven (SH)?			
A1 <input type="checkbox"/> Yes <input type="checkbox"/> No			
A2 <input type="checkbox"/> Yes <input type="checkbox"/> No			
If Yes to above, approximate date started _____			
Regardless of where they stayed last night, number of time client has been on the streets, in ES or SH in the past three years including today?			
A1 _____		A2 _____	
Total number of months homeless on the street, in ES or SH in the past three years?			
A1 _____		A2 _____	
Length of Time Homeless-Status Documented			
A1 <input type="checkbox"/> Yes <input type="checkbox"/> No			
A2 <input type="checkbox"/> Yes <input type="checkbox"/> No			
Length of Stay in Previous Place?			
A1 A2		A1 A2	
<input type="checkbox"/> <input type="checkbox"/> 1 day or less		<input type="checkbox"/> <input type="checkbox"/> 2 days to 1 week	
<input type="checkbox"/> <input type="checkbox"/> More than 1 week but less than 1 month		<input type="checkbox"/> <input type="checkbox"/> 1 to 3 months	
<input type="checkbox"/> <input type="checkbox"/> More than 3 months but less than 1 year		<input type="checkbox"/> <input type="checkbox"/> 1 year or longer	
Client's Present/Last Address*	City	State	Zip

Last Permanent Zip Code if different than address above _____

Info Line Use Only

<p>This Section is for Homeless Prevention and Rapid Re-Housing Referrals Only</p> <p>It is For Data Entry Purposes Only – Do Not Ask Client</p>	
Assistance Type:	
<input type="checkbox"/> Rent Assistance:	<input type="checkbox"/> Security Deposit Assistance:
<input type="checkbox"/> Utility Assistance:	

Central Intake Form

INCOME

What income do you currently receive? (please check all that apply and fill in all dollar amounts)

Proof of Income? Yes No

Source and Amount of Income:	Applicant 1	Applicant 2	Applicant 3
<input type="checkbox"/> Earned Income			
<input type="checkbox"/> Unemployment Insurance			
<input type="checkbox"/> Supplemental Security Income (SSI)			
<input type="checkbox"/> Social Security Disability (SSDI)			
<input type="checkbox"/> Veterans Disability Income			
<input type="checkbox"/> Private Disability Insurance			
<input type="checkbox"/> Workers Compensation			
<input type="checkbox"/> Temporary Assistance for Needy Families (TANF)			
<input type="checkbox"/> General Assistance			
<input type="checkbox"/> Retirement Income from Social Security			
<input type="checkbox"/> Veteran's Pension			
<input type="checkbox"/> Pension from a former job			
<input type="checkbox"/> Child Support			
<input type="checkbox"/> Alimony or other Spousal Support			
<input type="checkbox"/> Other Source:			
Source of Non-Cash Benefit			
<input type="checkbox"/> Food Stamps (SNAP)			
<input type="checkbox"/> WIC – Special Supplemental Nutrition Program			
<input type="checkbox"/> TANF Child Care			
<input type="checkbox"/> TANF Transportation			
<input type="checkbox"/> Other TANF Funded Services:			
<input type="checkbox"/> Section 8, Public Housing or Other Rental Assistance			
<input type="checkbox"/> Temporary Rental Assistance			
<input type="checkbox"/> Other:			
Source of Health Insurance			
<input type="checkbox"/> Medicaid			
<input type="checkbox"/> Medicare			
<input type="checkbox"/> State Children's Health Insurance Program (SCHIP)			
<input type="checkbox"/> Veteran's Administration (VA) Medical Services			
<input type="checkbox"/> Employer Provided Health Insurance			
<input type="checkbox"/> COBRA			
<input type="checkbox"/> Private Pay Health Insurance			
<input type="checkbox"/> State Health Insurance for Adults			

Criminal History:

Do you have a felony record? A1 Yes No Are you or anyone else in your household required to register as a sex offender in any state? A1 Yes No

A2 Yes No A2 Yes No

Charged or convicted of arson? A1 Yes No

A2 Yes No

Central Intake Form

CHILDREN INFORMATION

<p>Child Name _____</p> <p>Child SSN _____</p> <p>Child Gender <input type="checkbox"/> Male <input type="checkbox"/> Female</p> <p>Child DOB _____ Age _____</p> <p>Health Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Source (see list on page 3): _____</p> <p>Permanent Custody: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Child Race: (check all that apply) <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused</p> <p>Child Ethnicity: (check one) <input type="checkbox"/> Hispanic <input type="checkbox"/> Don't Know <input type="checkbox"/> Non-Hispanic/Other <input type="checkbox"/> Refused</p> <p>Long-term disability? <input type="checkbox"/> Yes* <input type="checkbox"/> No Type of Disability: _____</p>
<p>Child Name _____</p> <p>Child SSN _____</p> <p>Child Gender <input type="checkbox"/> Male <input type="checkbox"/> Female</p> <p>Child DOB _____ Age _____</p> <p>Health Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Source (see list on page 3): _____</p> <p>Permanent Custody: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Child Race: (check all that apply) <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused</p> <p>Child Ethnicity: (check one) <input type="checkbox"/> Hispanic <input type="checkbox"/> Don't Know <input type="checkbox"/> Non-Hispanic/Other <input type="checkbox"/> Refused</p> <p>Long-term disability? <input type="checkbox"/> Yes* <input type="checkbox"/> No Type of Disability: _____</p>
<p>Child Name _____</p> <p>Child SSN _____</p> <p>Child Gender <input type="checkbox"/> Male <input type="checkbox"/> Female</p> <p>Child DOB _____ Age _____</p> <p>Health Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Source (see list on page 3): _____</p> <p>Permanent Custody: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Child Race: (check all that apply) <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused</p> <p>Child Ethnicity: (check one) <input type="checkbox"/> Hispanic <input type="checkbox"/> Don't Know <input type="checkbox"/> Non-Hispanic/Other <input type="checkbox"/> Refused</p> <p>Long-term disability? <input type="checkbox"/> Yes* <input type="checkbox"/> No Type of Disability: _____</p>
<p>Child Name _____</p> <p>Child SSN _____</p> <p>Child Gender <input type="checkbox"/> Male <input type="checkbox"/> Female</p> <p>Child DOB _____ Age _____</p> <p>Health Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Source (see list on page 3): _____</p> <p>Permanent Custody: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Child Race: (check all that apply) <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused</p> <p>Child Ethnicity: (check one) <input type="checkbox"/> Hispanic <input type="checkbox"/> Don't Know <input type="checkbox"/> Non-Hispanic/Other <input type="checkbox"/> Refused</p> <p>Long-term disability? <input type="checkbox"/> Yes* <input type="checkbox"/> No Type of Disability: _____</p>

NOTES: _____

Homeless Prevention and Rapid Re-Housing Staff Use Only – For TANF Applicants

Client Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

Needs Utility Assistance? **Yes** **No**



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 APPROVAL OF YOUR APPLICATION FOR ASSISTANCE
(Do not use to approve food assistance benefits)

Name	Assistance Group	
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	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 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.

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.)

- | | | |
|---|--|--|
| <input type="checkbox"/> OWF (cash assistance) | <input type="checkbox"/> Disability Financial Assistance | <input type="checkbox"/> Provision, Retention, Contingency (PRC) |
| <input type="checkbox"/> Medicaid | <input type="checkbox"/> Child Care (Title XX) | <input type="checkbox"/> Child Support (Title IV-D) |
| <input type="checkbox"/> Medicaid Waiver Services | <input type="checkbox"/> Medicaid – Disability Determination | <input type="checkbox"/> Medicaid – Managed Care |
| <input type="checkbox"/> Medicaid – Prior Authorization | | |

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

- I want to do my hearing by telephone.
- I need an interpreter at my state hearing.
- My preferred days/times for a hearing are: _____
(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.

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.

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. ODJFS will explain its reasons. Then, an ODJFS hearing officer will make a decision after the hearing.

Ohio Department of Job and Family Services
NOTICE OF DENIAL OF YOUR APPLICATION FOR ASSISTANCE
(Do not use to deny food assistance benefits, or to terminate cash or medical 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.

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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.)*

- | | | |
|---|--|--|
| <input type="checkbox"/> OWF (cash assistance) | <input type="checkbox"/> Disability Financial Assistance | <input type="checkbox"/> Provision, Retention, Contingency (PRC) |
| <input type="checkbox"/> Medicaid | <input type="checkbox"/> Child Care (Title XX) | <input type="checkbox"/> Child Support (Title IV-D) |
| <input type="checkbox"/> Medicaid Waiver Services | <input type="checkbox"/> Medicaid – Disability Determination | <input type="checkbox"/> Medicaid – Managed Care |
| <input type="checkbox"/> Medicaid – Prior Authorization | | |

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

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- 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.

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.

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. ODJFS will explain its reasons. Then, an ODJFS hearing officer will make a decision after the hearing.

