ABOUT BOOKMARKS

You can only navigate through the manual by clicking on a bookmark in the left hand column, using the schroll bar on the right hand side of the screen, or by using the “FIRST PAGE”, “PREVIOUS PAGE”, “NEXT PAGE”, or “LAST PAGE” buttons in the tool bar. If you pass the hand over the bookmarks you will notice that it turns to a pointer and when it is over a title it turns into a finger. You can then click and it will take you to that subject. If a bookmark has an arrow that means it has additional subjects listed under it. It can be expanded by clicking on the arrow. The arrow will now be pointing down and the additional subjects will appear slightly indented.

You can view the manual without the bookmarks at any point by clicking on the first button in the tool bar. This will expand the right side of the page so it will be easier to read. Click on the second button from the right on the tool bar to return the bookmarks.

OHIO DEPARTMENT OF HUMAN SERVICES
CRIS-E CLIENT NOTICE REFERENCE BOOK

Welcome to the latest edition of the CRIS-E NOTICE REFERENCE BOOK. This is version number 8.

We always welcome any comments, criticisms or suggestions. Please direct all comments to:

NOTICES@ODHS.STATE.OH.US

This document utilizes bookmarks. They are listed on the left of the screen. To go to a particular subject click on that bookmark. For more on bookmarks click on “Using Bookmarks”. When clicking on a notice type you will first view a sample of the notice. If you want to view the “information” sheet about that notice, go back one page. The notices in this edition reflect the current state as of **3/22/2001**.

Before printing all or part of this document please click on the bookmark titled “Printing this document”.

WHAT'S NEW FOR RELEASE NUMBER 7

1. Notices Changed:

2. New Notices:

AD45N5

3. New

The new "Spend-Down" text that can appear on certain notices has been added under the Bookmark entitled Notice Attachments. This Bookmark will be used for items that are not stand-alone notices but may appear as part of other production notices.

You should use caution when attempting to print all or part of this document. The document consists of a total of 423 pages. If you want to print the whole document please be advised that this could take a **VERY LONG TIME!!** If you are attempting to print only a portion of it, **BE CAREFUL**. When the print dialog box appears it will be set to print the entire 423 pages. **YOU MUST CHANGE THE PRINT RANGE TO "CURRENT PAGE" OR "PAGES FROM: ????? TO: ?????"**. You can determine the page number you are on from the status bar in the bottom left hand corner.

USING ADOBE READER IN THIS APPLICATION

Now that you have entered the CRIS-E Notice Manual the ADOBE READER tool bar will be available to you at the top of the screen. If you click on HELP and then READER ONLINE GUIDE there are a series of help screens explaining how ADOBE READER works and how to use the different buttons to navigate a through a document. These are for general use on any PDF (ADOBE) document. Here we will try to give you a brief explanation of the particular buttons which may be of the most use to you as you view the CRIS-E Notice Manual. For general navigation of the manual you probably want to use the ***HAND*** button but try out the different buttons and see what each does.

The first group of three buttons determine what the document will display. This manual uses bookmarks so, when the document opens the second button should already be “pushed” and the bookmarks should appear on the left of the screen. You may wish to view the document at times without the bookmarks. You can remove the bookmarks by pushing the first button. This will enable you to view the document over the entire screen. To display the bookmarks again (they are the only way you can navigate through the document other than a page at a time) push the second button.

The second group of three buttons can all be used. The hand button is the main one you will want to use while in this document. It will automatically be pushed when you enter the document. You should be able to view anything in the manual while this button is pushed. The zoom button allows you to enlarge or decrease the size of the document. After pushing the zoom button the hand will change to a magnifying glass with a Plus (+) sign in the middle. While the plus sign is there each time you click the mouse the size of the document will increase. To change the plus to a minus (-) hold down the CTRL key.

When the minus is displayed in the magnifying glass and you click the mouse the size of the document will decrease. The third button in this group is the text selection button. It allows you to select certain parts of the text of the document. The selected text will be enclosed in a box.

The next group consisting of four buttons allows you to move around in the document. The first button will always take you to the first page of the document. The next button will take you to the previous page of the document.the third button in this group will take you to the next page and the final button will take you to the last page in the document. The CRIS-E Notice Manual consists of several documents. Each example ofa notice is its own document so if you are viewing a particular notice and press the first page button it will take you to the first page of that notice. All of the informational lists provided with the manual are also contained in their own document and work the same way.

The fourth set of two buttons do somewhat the same as the last group. The first one in this group takes you to the last thing you viewed and the second button returns you to the next view.

The next set of three buttons affect how the entire page appears to you. The first one shows the page at 100%. The second one fits the page within the window and the third one fits the current width within the window. These buttons may affect different documents in different ways.

The next button displays the find dialog. This lets you type in a word or several words and the ADOBE READER will find all occurrences of what you typed in the current document. Again keep in mind that the CRIS-E Notice Manual consists of several individual documents.

The final set of four buttons deal with the search fucntion. This lets you search for text as you can in the find button. However,

the search function will look for the text you type through-out the entire manual. The first button brings up the search dialog. The second button will bring up a list of all of the individual documents where the requested text was found. From here you can view any of the individual documents. The third button will display the previous result that you viewed and the fourth button will display the next result available.

COMPLETE LIST BY SUB-SYSTEM

AD-HOC NOTICES:

AD42N1 AD44N1 AD45N1 AD45N2 AD45N3 AD45N4

APPLICATION ENTRY NOTICES:

AE01A1 AE01A2 AE01A3 AE01A4 AE01A5 AE01A6
AE01A7 AE01A8 AE01A9 AE01AA AE01AB AE01AC
AE01AD AE01AE AE01AF AE01AM AE01AN AE01C1
AE01D1 AE01D2 AE01H1 AE01I1 AE01I2 AE01I3
AE01M1 AE01R1 AE01R2 AE01R3 AE01T1 AE01T2
AE01X2 AE01X3 AE01Z1 AE01Z2 AE04C1 AE04I1
AE04I2 AE04I3 AE04M1 AE04R1 AE04R2 AE04R3
AE04T1 AE04T2 AE04X2 AE05F1 AE07TM AE09M1
AE10M1 AE21A1 AE21A3 AE21A4 AE21D1 AE21D2
AE21D3 AE22A1 AE22A2 AE22D3 AE24C1 AE24L1
AE24L2 AE25L1

APPLICATION REGISTRATION NOTICES:

AR01J1 AR02J2 AR03J3 AR04D1

BENEFIT ISSUANCE NOTICES:

BIO1X1 BI01X2 BI01X5 BI02N1

BENEFIT RECOVERY NOTICES:

BV04A1 BV04A2 BV04A3 BV04A4 BV04A5 BV04A6
BV04A7 BV05O1 BV07O1 BV12O1 BV13O1 BV15O1
BV16O1 BV20O1 BV21O1 BV30O1 BV31O1 BV32O1
BV33O1 BV60A1 BV61A1 BV62A1 BV63A1 BV64A1
BV70A1 BV71A1 BV72A1 BV74A1

CASELOAD MANAGEMENT NOTICES:

CM01E1 CM03N1 CM04P1 CM05R1

CLIENT SCHEDULING NOTICES:

CS01C2 CS02C3 CS03C4 CS04A1

DATA EXCHANGE NOTICES:

DE01B1 DE02B2 DE02B3 DE03B4

EXPEDITED MEDICAID NOTICES:

EZ01C1 EZ02C1 EZ03D1 EZ04N1 EZ04N2

HEALTH INSURANCE NOTICES:

HI01I1

HEALTH MAINTENANCE NOTICES:

HM01NP HM01NV HM01N1 HM02N1 HM02N2

HEARING SCHEDULING NOTICES:

HS01N1 HS01N2 HS01N5 HS02N1 HS02N2 HS02N5
HS03N1 HS03N2 HS03N5 HS04N1 HS04N2 HS04N5

MASS CHANGE NOTICES:

MC01C1 MC01I1 MC01I2 MC01I3 MC01R1 MC01R2
MC01R3 MC01T1 MC01T3

PERIODIC REPORTING NOTICES:

PR01A1 PR01A2 PR01A3 PR01A4 PR01A5 PR01AA

WORK PROGRAM NOTICES:

WP02W2 WP03W3 WP06A1 WP06A2 WP06A3 WP06A4
WP06A5

AD-HOC NOTICES

AD42N1 AD44N1 AD45N1 AD45N2 AD45N3
AD45N4

APPLICATION ENTRY NOTICES

AE01A1	AE01A2	AE01A3	AE01A4	AE01A5	AE01A6
AE01A7	AE01A8	AE01A9	AE01AA	AE01AB	AE01AC
AE01AD	AE01AE	AE01AF	AE01AM	AE01AN	AE01C1
AE01D1	AE01D2	AE01H1	AE01I1	AE01I2	AE01I3
AE01M1	AE01R1	AE01R2	AE01R3	AE01T1	AE01T2
AE01X2	AE01X3	AE01Z1	AE01Z2	AE04C1	AE04I1
AE04I2	AE04I3	AE04M1	AE04R1	AE04R2	AE04R3
AE04T1	AE04T2	AE04X2	AE05F1	AE07TM	AE09M1
AE10M1	AE21A1	AE21A3	AE21A4	AE21D1	AE21D2
AE21D3	AE22A1	AE22A2	AE22D3	AE24C1	AE24L1
AE24L2	AE25L1				

APPLICATION REGISTRATION NOTICES

AR01J1 AR02J2 AR03J3 AR04D1

BENEFIT ISSUANCE NOTICES

BI01X1 BI01X2 BI01X5 BI02N1

BENEFIT RECOVERY NOTICES

BV04A1	BV04A2	BV04A3	BV04A4	BV04A5	BV04A6
BV04A7	BV05O1	BV07O1	BV12O1	BV13O1	BV15O1
BV16O1	BV20O1	BV21O1	BV30O1	BV31O1	BV32O1
BV33O1	BV60A1	BV61A1	BV62A1	BV63A1	BV64A1
BV70A1	BV71A1	BV72A1	BV74A1		

CASELOAD MANAGEMENT NOTICES

CM01E1 CM03N1 CM04P1 CM05R1

CLIENT SCHEDULING NOTICES

CS01C2 CS02C3 CS03C4 CS04A1

DATA EXCHANGE NOTICES

DE01B1 DE02B2 DE02B3 DE03B4

EXPEDITED MEDICAID NOTICES

EZ01C1 EZ02C1 EZ03D1 EZ04N1 EZ04N2

HEALTH INSSURANCE NOTICES

HI01I1

HEALTH MAINTENANCE NOTICES

HM01NP HM01NV HM01N1 HM02N1 HM02N2

HEARINGS SCHEDULING NOTICES

HS01N1 HS01N2 HS01N5 HS02N1 HS02N2 HS02N5
HS03N1 HS03N2 HS03N5 HS04N1 HS04N2 HS04N5

MASS CHANGE NOTICES

MC01C1 MC01I1 MC01I2 MC01I3 MC01R1
MC01R2 MC01R3 MC01T1 MC01T3

PERIODIC REPORTING NOTICES

WORK PROGRAM NOTICES

WP02W2 WP03W3 WP06A1 WP06A2 WP06A3
WP06A4 WP06A5

NOTICE ATTACHMENTS

Spend-Down

COMPLETE LIST BY SUB-SYSTEM

AD-HOC Notices

AD42N1	Monthly time limits notice.
AD44N1	Provides final warning for recipients reaching 36 months.
AD45N1	Anouncement of Medicaid reinstatement.
AD45N2	Medicaid reinstatement application packet.
AD45N3	Past Medical Benefits explanation.
AD45N4	Medicaid reinstatement reminder notice.

Application Entry Notices

AE01A1	Approval of MA (no OSS, no spenddown, no patient liability).
AE01A2	Retroactive approval of Food Stamps.
AE01A3	Retroactive approval of Medicaid.
AE01A4	Retroactive approval of ADC, MA (OSS only).
AE01A5	Approval of ADC, MA (OSS only); Non-retro approvals only.
AE01A6	Notice of approval - Medicaid Spendown > 0.
AE01A7	Notice of approval-Nursing home liability only; Co-payment amt greater than zero.
AE01A8	Approval of Food Stamps. No retroactive benefits.
AE01A9	Approval of expedited Food Stamps.
AE01AA	Approval of Medicaid vendor payment with retroactive benefits.
AE01AB	Approval of QMB Medicaid (no retro).
AE01AC	Approval of retroactive QMB Medicaid.
AE01AD	Notice of nursing home vender payment denial due to improper resource transfer.
AE01AE	Notice of ineligibility for LTC due to an improper resource transfer; Requested in addition to regular approval notice.
AE01AF	Termination of nursing home vendor pay due to improper resource transfer.
AE01AM	SLMB Approval without retroactive benefits.
AE01AN	SLMB Approval with retroactive benefits.

AE01C1	Notice of continued benefits; Benefits have been recalculated, but no changes occurred. Only if reason code is 53.
AE01D1	Notice of denial of benefits; One assistance groups have been denied.
AE01D2	SLMB Denial (with spend-down Medicaid approval or denial); SLMB denied and spend-down medicaid approved or denied. Accompanied by spend-down medicaid approval or denial. Generates one notice per request.
AE01H1	Notice of Adverse Action - Held Benefit.
AE01I1	Benefit increase.
AE01I2	MA decrease of spenddown amount.
AE01I3	MA decrease of patient liability (long term care) - Increased benefit.
AE01M1	Notice of no change in benefit although there has been a change in eligible individuals.
AE01R1	Reduction of benefit.
AE01R2	Medicaid increase of spenddown amount.
AE01R3	Medicaid increase of patient liability amount.
AE01T1	Notice of Termination of Benefit.
AE01T2	Termination of benefit.
AE01X2	Benefit adjustment with aux check.
AE01X3	LEAP auxiliary payment.
AE01Z1	A description of changes to a case with reasons (OWF).
AE01Z2	A description of changes to a case with reason (FS).
AE04C1	Notice of continued benefits. Benefits have been recalculated, but no changes occurred.
AE04I1	Benefit increase. Priority one reason codes.
AE04I2	MA decrease of spenddown amount - big 10 reason code. A decrease in spenddown translates into an increase in benefits for the client. Big 10 reason codes.
AE04I3	MA decrease of patient liability (long term care). A decrease in patient liability translates to an increase in benefits for the client. Big 10 reason codes.
AE04M1	Notice of no change in benefits although there has been a change in eligible individuals. Big Ten Reason Codes.
AE04R1	Reduction of benefit. Big 10 reason codes.

AE04R2	Medicaid increase of spenddown amount. An increase in spenddown translates into a decrease in benefits for the client. Big 10 reason codes.
AE04R3	Medicaid increase of patient liability amount. An increase in patient liability translates into a decrease in benefits for the client. BIG 10 reason codes.
AE04T1	Termination of benefit.
AE04T2	Termination of benefit - big ten reason code.
AE04X2	Benefit increase with aux check.
AE05F1	Notice of inter-county transfer; one per AG.
AE07TM	Transitional ADC-related Medicaid.
AE09M1	Notice of excess spousal resources; Refusal of community spouse to cooperate with resource transfer.
AE10M1	Expedited Medicaid Approval Notice.
AE21A1	Approval of disability medical assistance (all members are medication dependent).
AE21A3	Retro approval of disability assistance cash benefits (all members are medication dependent).
AE21A4	Retro approval of disability assistance cash benefits (at least one member is medication dependent and one member eligible for DA under another covered group).
AE21D1	Denial of cash benefits; no cash eligibility and/or all members are medication dependent.
AE21D2	Denial of medical benefits.
AE21D3	GA-A denial with no retroactive; MA-G denial.
AE22A1	Retro approval of general assistance cash (no recurring eligibility).
AE22A2	Approval of General Assistance medical benefits for retro period prior to 8/1/95 only. No recurring eligibility.
AE22D3	GA-U denial and failed retroactive for reasons unrelated to AM. H. B. 249.
AE24C1	Continuation of medical benefits.
AE24L1	Reduction in benefits-refusal to sign consent. Reduction of ADC benefits because 1 or more members failed to cooperate in the learnfare program.
AE24L2	Imposition of one month attendance sanction. Reduction of ADC benefits indicating amount and month its effective and the month theinfraction occurred.
AE25L1	Learnfare warning notice -

	Informing participant in learnfare of first infraction and penalty for second

Application Registration Notices

AR01J1	Hospital Referral Notice - Initial (notice sent to client).
AR02J2	Hospital Referral Notice - Second (sent to client).
AR03J3	Hospital Referral Notice - Non-Compliance (sent to provider).
AR04D1	Notice of Denial.

Benefit Issuance Notices

BI01X1	Notice of Underpayment; also generates BI01X5 and/or BI01X2.
BI01X2	Notice of Underpayment (payment via aux check); Generated in addition to BI01X1. Assistance Groups will receive an Auxiliary check will also generate this notice.
BI01X5	Notice of Underpayment (with outstanding recoupment); Generated in addition to BI01X1. Assistance Groups which have outstanding recoupments will also generate notice BI01X1.
BI02N1	Notification of an electronic deposit.

Benefit Recovery Notices

BV04A1	Repayment Summary; Payment was made as negotiated.
BV04A2	Repayment Summary; No payment was made. (Open AG).
BV04A3	Repayment Summary; No payment was made (closed AG).
BV04A4	Repayment Summary; First partial payment (open FS AG - claim type IPV or IHE).
BV04A5	Repayment Summary; First partial payment (closed FS with claim type IPV or IHE).
BV04A6	Repayment Summary; Second partial payment (open FS with clain type IPV or IHE).
BV04A7	Repayment Summary; Second partial payment [closed FS - claim type IPV or IHE; all ADC, GA].
BV05O1	Notice of medicaid overpayment.
BV07O1	Overpayment of benefits (recoupment).

BV12O1	This notice is generated when a worker enters a new claim for an ADC assistance group that has a status of 'O' (open) or 'S' (suspended) and a claim status of 'OA' (open awaiting). 'Open Awaiting' means that a claim is now open and is awaiting recipient response to the notice.
BV13O1	This notice is generated when a worker enters a new claim for an ADC assistance group with a 'closed' status and a claim status of 'OA' (open awaiting). 'Open Awaiting' means that a claim is now open and is awaiting recipient response to the notice.
BV15O1	Notice of ADC overpayment - only open assistance groups and ADC fraud sanctioned.
BV16O1	Notice of ADC overpayment - only closed assistance groups and ADC fraud sanctioned.
BV20O1	Notice of General Assistance Overpayment; Open or suspended AGs.
BV21O1	General Assistance Repayment Agreement - Demand Letter; Closed AG's only.
BV30O1	Food Stamp Repayment Agreement - Demand Letter; Open or suspended FS AG's with claim error type 'AE'.
BV31O1	Food Stamp Repayment Agreement - Demand Letter; Closed FS AG's with claim error type 'AE', 'IHE', or 'IPV'
BV32O1	Food Stamp Repayment Agreement - Demand Letter; Open FS AG's with claim error type 'IPV' or 'IHE'.
BV33O1	Notice of ADC or FS overpayment for claims with a work allowance violation type.
BV60A1	60 Day Tax Offset Notice (Federal). This notice indicates the intent of the state to refer client for Federal Tax Offset.
BV61A1	Offset Notice (Federal) - Indicates a collection and the status of outstanding claims.
BV62A1	This is a refund notice that indicates a refund has occurred and the amount refunded.
BV63A1	This is a reversal notice that indicates the reestablishment of a claim due to a reversal.
BV64A1	This is a cancellation notice which explains referral has been canceled and reason. (Bankruptcy/Not Legally Enforceable).
BV70A1	30 Day Tax Offset Notice (State). This notice

	indicates the intent of the state to refer client for State Tax Offset.
BV71A1	Offset Notice (State) - Indicates a collection and the status of outstanding claims.
BV72A1	This is a refund notice that indicates a refund has occurred and the amount refunded.
BV74A1	This is a cancellation notice which explains referral has been cancelled and the reason (Bankruptcy/Not Legally Enforcable).

Caseload Management Notices

CM01E1	Expiration of Food Stamps - non MR (monthly repeating).
CM03N1	New caseworker notice; Generate one per case.
CM04P1	Application followup letter; Generate one per pending AG.
CM05R1	Notice of failure to submit resource documentation; When any spousal resource verification codes not equal to yes.

Client Scheduling Notices

CS01C2	Notice of application appointment interview; Worker Type is the activity code of the interview.
CS02C3	Notice of reapplication interview; Worker Type is the activity code of the interview.
CS03C4	Notice of appointment letter (generic); Worker Type is the activity code of the interview.
CS04A1	Appointment Letter (JOBS); For JOBS assessment interview (rights, responsibilities)

Data Exchange Notices

DE01B1	Initial notice of child support disregard payment; No previous child support disregard payments have been made and no previous notice has been sent.
DE02B2	Notice of change in child support disregard payment; Send when current month payment is greater than zero and not equal to the previous monthly payment.
DE02B3	(CRIS) notice of change in child support disregard payment. Send when the current month payment is equal to zero and the previous monthly payment is

	greater than zero.
DE03B4	Notice of additional child support disregard payment. Send when the current month payment is equal to zero and the previous monthly payment is greater than zero.

Expedited Medicaid Notices

EZ01C1	PAYEASE notice of credit.
EZ02C1	PAYEASE notice of charge.
EZ03D1	PAYEASE notice of debit.
EZ04N1	PAYEASE notice of non-use of Food Stamp card.
EZ04N2	PAYEASE notice of non-use of Food Stamp card.

Health Insurance Notices

HI01I1	Certificate of Group Health Plan Coverage.

Health Maintenance Notices

HM01NP	Healthy Start, Healthy Families or Ohio Works First approval notice.
HM01NV	Healthy Start, Healthy Families or Ohio Works First approval notice.
HM01N1	Explain to recipient they must join HMO. 1-800 number given.
HM02N1	Managed Care Plan - open enrollment.
HM02N2	Managed Care Plan - open enrollment.

Hearing Scheduling Notices

HS01N1	State hearing scheduling notice addressed to appellant.
HS01N2	State hearing scheduling notice addressed to the CDHS.
HS01N5	State hearing scheduling notice addressed to agency representative.
HS02N1	State hearing dismissal notice (hearing request denied) addressed to the appellant.
HS02N2	State hearing dismissal notice (hearing request denied) addressed to the CDHS.
HS02N5	State hearing dismissal notice (hearing request denied) addressed to the agency representative.
HS03N1	State hearing dismissal notice (hearing request withdrawn in writing) addressed to the appellant.
HS03N2	State hearing dismissal notice (hearing request withdrawn in writing) addressed to the CDHS.

HS03N5	State hearing dismissal notice (hearing request withdrawn in writing) addressed to the agency representative.
HS04N1	State hearing dismissal notice (appellant or repersentative did not show) addressed to the appellant.
HS04N2	State hearing dismissal notice (appellant or representative did not show) addressed to CDHS.
HS04N5	State hearing dismissal notice (appellant or representative did not show) addressed to the agency representative.

Mass Change Notices

MC01C1	Notice of right to state hearing - change in law or policy; No benefit change resulting from GA/DA implementation. Will not be generated any more.
MC01I1	Notice Of Right To State Hearing - Change In Law Or Policy; Benefit increase due to GA/DA implementation.
MC01I2	Decrease in spenddown liability due to mass change.
MC01I3	Decrease in patient liability due to mass change.
MC01R1	Notice of right to state hearing - change in law or policy. Benefit decrease due to GA/DA implementation.
MC01R2	Increase in spenddown liability due to mass change.
MC01R3	Increase in patient liability amount due to mass change.
MC01T1	Notice of benefit termination due to mass change.
MC01T3	Medication dependent mass change - termination of cash benefits.

Periodic Reporting Notices

PR01A1	Transitional ADC-related Medicaid Quarterly Report (Part 1).
PR01A2	Transitional ADC-related Medicaid Quarterly Report (Part 2).
PR01A3	Transitional ADC-related Medicaid Quarterly Report (Part 3).
PR01A4	Transitional ADC-related Medicaid Quarterly Report (Part 4).
PR01A5	Transitional ADC-related Medicaid Quarterly Report (Part 5).

PR01AA	Transitional ADC-related Medicaid Quarterly Report (All); Includes fill-in parts 1 thru 5.

Work Program Notices

WP02W2	Individual work schedule(worksite copy).
WP03W3	Work schedule(participant copy).
WP06A1	LEAP Notice - school report of unexcused & excused absences.
WP06A2	LEAP Notice - absences from GED program; Initial notice.
WP06A3	LEAP Notice - excessive unexcused absences.
WP06A4	LEAP Notice - not enrolled.
WP06A5	LEAP Notice - no verification of enrollment.

AD-HOC NOTICES

Client Notice	Description
AD42N1	Monthly time limits notice.
AD44N1	Provides final warning for recipients reaching 36 months.
AD45N1	Anouncement of Medicaid reinstatement.
AD45N2	Medicaid reinstatement application packet.
AD45N3	Past Medical benefits explanation.
AD45N4	Medicaid reinstatement reminder notice.

APPLICATION ENTRY NOTICES

Client Notice	Description
AE01A1	Approval of MA (no OSS, no spenddown, no patient liability).
AE01A2	Retroactive approval of Food Stamps
AE01A3	Retroactive approval of Medicaid
AE01A4	Retroactive approval of ADC, MA (OSS only).
AE01A5	Approval of ADC, MA (OSS only); Non-retro approvals only.
AE01A6	Notice of approval - Medicaid Spendown > 0
AE01A7	Notice of approval-Nursing home liability only; Co-payment amt greater than zero.
AE01A8	Approval of Food Stamps. No retroactive benefits.
AE01A9	Approval of expedited Food Stamps.
AE01AA	Approval of Medicaid vendor payment with retroactive benefits.
AE01AB	Approval of QMB Medicaid (no retro)
AE01AC	Approval of retroactive QMB Medicaid
AE01AD	Notice of nursing home vender payment denial due to improper resource transfer.
AE01AE	Notice of ineligibility for LTC due to an improper resource transfer; Requested in addition to regular approval notice.
AE01AF	Termination of nursing home vendor pay due to improper resource transfer.
AE01AM	SLMB Approval without retroactive benefits.
AE01AN	SLMB Approval with retroactive benefits.
AE01C1	Notice of continued benefits; Benefits have been recalculated, but no changes occurred. Only if reason code is 53.
AE01D1	Notice of denial of benefits; One assistance groups have been denied.
AE01D2	SLMB Denial (with spend-down Medicaid approval or denial); SLMB denied and spend-down medicaid approved or denied. Accompanied by spend-down medicaid approval or denial. Generates one notice per request.
AE01H1	Notice of Adverse Action - Held Benefit.

AE01I1	Benefit increase.
AE01I2	MA decrease of spenddown amount.
AE01I3	MA decrease of patient liability (long term care) - Increased benefit.
AE01M1	Notice of no change in benefit although there has been a change in eligible individuals.
AE01R1	Reduction of benefit.
AE01R2	Medicaid increase of spenddown amount.
AE01R3	Medicaid increase of patient liability amount.
AE01T1	Notice of Termination of Benefit.
AE01T2	Termination of benefit.
AE01X2	Benefit adjustment with aux check.
AE01X3	LEAP auxiliary payment.
AE01Z1	A description of changes to a case with reasons (OWF).
AE01Z2	A description of changes to a case with reason (FS).
AE04C1	Notice of continued benefits. Benefits have been recalculated, but no changes occurred.
AE04I1	Benefit increase. Priority one reason codes.
AE04I2	MA decrease of spenddown amount - big 10 reason code. A decrease in spenddown translates into an increase in benefits for the client. Big 10 reason codes.
AE04I3	MA decrease of patient liability (long term care). A decrease in patient liability translates to an increase in benefits for the client. Big 10 reason codes.
AE04M1	Notice of no change in benefits although there has been a change in eligible individuals. Big Ten Reason Codes.
AE04R1	Reduction of benefit. Big 10 reason codes.
AE04R2	Medicaid increase of spenddown amount. An increase in spenddown translates into a decrease in benefits for the client. Big 10 reason codes.
AE04R3	Medicaid increase of patient liability amount. An increase in patient liability translates into a decrease in benefits for the client. BIG 10 reason codes.
AE04T1	Termination of benefit.
AE04T2	Termination of benefit - big ten reason code.
AE04X2	Benefit increase with aux check.
AE05F1	Notice of inter-county transfer; one per AG.
AE07TM	Transitional ADC-related Medicaid.

AE09M1	Notice of excess spousal resources; Refusal of community spouse to cooperate with resource transfer.
AE10M1	Expedited Medicaid Approval Notice.
AE21A1	Approval of disability medical assistance (all members are medication dependent).
AE21A3	Retro approval of disability assistance cash benefits (all members are medication dependent).
AE21A4	Retro approval of disability assistance cash benefits (at least one member is medication dependent and one member eligible for DA under another covered group).
AE21D1	Denial of cash benefits; no cash eligibility and/or all members are medication dependent.
AE21D2	Denial of medical benefits.
AE21D3	GA-A denial with no retroactive; MA-G denial.
AE22A1	Retro approval of general assistance cash (no recurring eligibility)
AE22A2	Approval of General Assistance medical benefits for retro period prior to 8/1/95 only. No recurring eligibility.
AE22D3	GA-U denial and failed retroactive for reasons unrelated to AM. H. B. 249.
AE24C1	Continuation of medical benefits
AE24L1	Reduction in benefits-refusal to sign consent. Reduction of ADC benefits because 1 or more members failed to cooperate in the learnfare program.
AE24L2	Imposition of one month attendance sanction. Reduction of ADC benefits indicating amount and month its effective and the month theinfraction occurred.
AE25L1	Learnfare warning notice - informing participant in learnfare of first infraction and penalty for second.

APPLICATION REGISTRATION NOTICES

Client Notice	Description
AR01J1	Hospital Referral Notice - Initial (notice sent to client).
AR02J2	Hospital Referral Notice - Second (sent to client).
AR03J3	Hospital Referral Notice - Non-Compliance (sent to provider).
AR04D1	Notice of Denial.

BENEFIT ISSUANCE NOTICES

Client Notice	Description
BI01X1	Notice of Underpayment; also generates BI01X5 and/or BI01X2.
BI01X2	Notice of Underpayment (payment via aux check); Generated in addition to BI01X1. Assistance Groups will receive an Auxiliary check will also generate this notice.
BI01X5	Notice of Underpayment (with outstanding recoupment); Generated in addition to BI01X1. Assistance Groups which have outstanding recoupments will also generate notice BI01X1.
BI02N1	Notification of an electronic deposit.

BENEFIT RECOVERY NOTICES

Client Notice	Description
BV04A1	Repayment Summary; Payment was made as negotiated.
BV04A2	Repayment Summary; No payment was made. (Open AG).
BV04A3	Repayment Summary; No payment was made (closed AG).
BV04A4	Repayment Summary; First partial payment (open FS AG - claim type IPV or IHE).
BV04A5	Repayment Summary; First partial payment (closed FS with claim type IPV or IHE).
BV04A6	Repayment Summary; Second partial payment (open FS with clain type IPV or IHE).
BV04A7	Repayment Summary; Second partial payment (closed FS - claim type IPV or IHE; all ADC, GA).
BV05O1	Notice of medicaid overpayment.
BV07O1	Overpayment of benefits (recoupment).
BV12O1	This notice is generated when a worker enters a new claim for an ADC assistance group that has a status of 'O' (open) or 'S' (suspended) and a claim status of 'OA' (open awaiting). 'Open Awaiting' means that a claim is now open and is awaiting recipient response to the notice.
BV13O1	This notice is generated when a worker enters a new claim for an ADC assistance group with a 'closed' status and a claim status of 'OA' (open awaiting). 'Open Awaiting' means that a claim is now open and is awaiting recipient response to the notice.
BV15O1	Notice of ADC overpayment - only open assistance groups and ADC fraud sanctioned.
BV16O1	Notice of ADC overpayment - only closed assistance groups and ADC fraud sanctioned.
BV20O1	Notice of General Assistance Overpayment; Open or suspended AGs.
BV21O1	General Assistance Repayment Agreement - Demand Letter; Closed AG's only.
BV30O1	Food Stamp Repayment Agreement - Demand Letter; Open or suspended FS AG's with claim error type 'AE'.
BV31O1	Food Stamp Repayment Agreement - Demand Letter; Closed FS AG's with claim error type 'AE', 'IHE', or

	'IPV'.
BV32O1	Food Stamp Repayment Agreement - Demand Letter; Open FS AG's with claim error type 'IPV' or 'IHE'.
BV33O1	Notice of ADC or FS overpayment for claims with a work allowance violation type.
BV60A1	60 Day Tax Offset Notice. This notice indicates the intent of the state to refer client for Federal Tax Offset.
BV61A1	Offset Notice - Indicates a collection and the status of outstanding claims.
BV62A1	This is a refund notice that indicates a refund has occurred and the amount refunded.
BV63A1	This is a reversal notice that indicates the reestablishment of a claim due to a reversal.
BV64A1	This is a cancellation notice which explains referral has been canceled and reason. (Bankruptcy/Not Legally Enforceable).
BV70A1	30 Day State Tax Offset Notice. This notice indicates the intent of the state to refer client to the Ohio Department of Taxation.
BV71A1	State Offset Notice. Indicates a collection and the status of outstanding claims.
BV72A1	This is a refund notice that indicates a refund has occurred and the amount refunded.
BV74A1	This is a cancellation notice which explains referral has been canceled and reason (Bankruptcy/Not Legally Enforceable).

CASELOAD MANAGEMENT NOTICES

Client Notice	Description
CM01E1	Expiration of Food Stamps - non MR (monthly repeating)
CM03N1	New caseworker notice; Generate one per case.
CM04P1	Application followup letter; Generate one per pending AG.
CM05R1	Notice of failure to submit resource documentation; When any spousal resource verification codes not equal to yes.

CLIENT SCHEDULING NOTICES

Client Notice	Description
CS01C2	Notice of application appointment interview; Worker Type is the activity code of the interview.
CS02C3	Notice of reapplication interview; Worker Type is the activity code of the interview.
CS03C4	Notice of appointment letter (generic); Worker Type is the activity code of the interview.
CS04A1	Appointment Letter (JOBS); For JOBS assessment interview (rights, responsibilities).

DATA EXCHANGE NOTICES

Client Notice	Description
DE01B1	Initial notice of child support disregard payment; No previous child support disregard payments have been made and no previous notice has been sent.
DE02B2	Notice of change in child support disregard payment; Send when current month payment is greater than zero and not equal to the previous monthly payment.
DE02B3	(CRIS) notice of change in child support disregard payment. Send when the current month payment is equal to zero and the previous monthly payment is greater than zero.
DE03B4	Notice of additional child support disregard payment. Send when the current month payment is equal to zero and the previous monthly payment is greater than zero.

EXPEDITED MEDICAID NOTICES

Client Notice	Description
EZ01C1	PAYEASE notice of credit.
EZ02C1	PAYEASE notice of charge.
EZ03D1	PAYEASE notice of debit.
EZ04N1	PAYEASE notice of non-use of Food Stamp card.
EZ04N2	PAYEASE notice of non-use of Food Stamp card.

HEALTH INSURANCE NOTICES

Client Notice	Description
HI01I1	Certificate of Group Health Plan Coverage

HEALTH MAINTENANCE NOTICES

Client Notice	Description
HM01NP	Healthy Start, Healthy Families or Ohio Works First approval notice. Explains that the recipient must now choose a health care provider.
HM01NV	Healthy Start, Healthy Families or Ohio Works First approval notice. Explains that the recipient must now choose a health care provider by a specified date.
HM01N1	Explain to recipient they must join HMO. 1-800 number given.
HM02N1	Managed Care Plan - open enrollment.
HM02N2	Managed Care Plan - open enrollment.

HEARING SCHEDULING NOTICES

Client Notice	Description
HS01N1	State hearing scheduling notice addressed to the appellant.
HS01N2	State hearing scheduling notice addressed to the CDHS.
HS01N5	State hearing scheduling notice addressed to the agency representative.
HS02N1	State hearing dismissal notice (hearing request denied) addressed to the appellant.
HS02N2	State hearing dismissal notice (hearing request denied) addressed to the CDHS.
HS02N5	State hearing dismissal notice (hearing request denied) addressed to the agency representative.
HS03N1	State hearing dismissal notice (hearing request withdrawn in writing) addressed to the appellant.
HS03N2	State hearing dismissal notice (hearing request withdrawn in writing) addressed to the CDHS.
HS03N5	State hearing dismissal notice (hearing request withdrawn in writing) addressed to the agency representative.
HS04N1	State hearing dismissal notice (appellant or representative did not show) addressed to the appellant.
HS04N2	State hearing dismissal notice (appellant or representative did not show) addressed to the CDHS.
HS04N5	State hearng dismissal notice (appellant or representative did not show) addressed to the agency representative.

MASS CHANGE NOTICES

Client Notice	Description
MC01C1	Notice of right to state hearing - change in law or policy; No benefit change resulting from GA/DA implementation. Will not be generated any more.
MC01I1	Notice Of Right To State Hearing - Change In Law Or Policy; Benefit increase due to GA/DA implementation.
MC01I2	Decrease in spenddown liability due to mass change.
MC01I3	Decrease in patient liability due to mass change.
MC01R1	Notice of right to state hearing - change in law or policy. Benefit decrease due to GA/DA implementation.
MC01R2	Increase in spenddown liability due to mass change.
MC01R3	Increase in patient liability amount due to mass change.
MC01T1	Notice of benefit termination due to mass change
MC01T3	MEDICATION DEPENDENT MASS CHANGE - termination of cash benefits.

PERIODIC REPORTING NOTICES

Client Notice	Description
PR01A1	Transitional ADC-related Medicaid Quarterly Report (Part 1).
PR01A2	Transitional ADC-related Medicaid Quarterly Report (Part 2).
PR01A3	Transitional ADC-related Medicaid Quarterly Report (Part 3).
PR01A4	Transitional ADC-related Medicaid Quarterly Report (Part 4).
PR01A5	Transitional ADC-related Medicaid Quarterly Report (Part 5).
PR01AA	Transitional ADC-related Medicaid Quarterly Report (All); Includes fill-in parts 1 thru 5.

WORK PROGRAM NOTICES

Client Notice	Description
WP02W2	Individual work schedule(worksite copy).
WP03W3	Work schedule(participant copy).
WP06A1	LEAP Notice - school report of unexcused & excused absences.
WP06A2	LEAP Notice - absences from GED program; Initial notice.
WP06A3	LEAP Notice - excessive unexcused absences.
WP06A4	LEAP Notice - not enrolled.
WP06A5	LEAP Notice - no verification of enrollment.

Client Notice: AD42N1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number: 98009-17

Date Implemented: 03/17/98

Last Date Revised: July, 2000

Description of Notice: This notice provides a monthly statement of how many months of OWF have been used and how many of the maximum 36 months remains.

Assistance Group(s): OWF.

Hearing Rights: NO

Program ID: GCN093

Transaction ID:

Frequency: Monthly

Volume (est. monthly): 30,000

Form Number: DHS 8500

Notes:

WMLH 0066

0000001

IMPORTANT NOTICE

FAIRFIELD COUNTY DEPT OF HUMAN SERVICES
P.O. BOX 890

LANCASTER OH 431300000

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 12/01/1999
From: MISTY L HUSTON
Phone: (614) 653-1701 Ext: 6808

Worker ID: WMLH23
Case Number: 9999999999
AG Name: JANE DOE

Official Notice

As of 12/01/1999 you have used 25 months of your initial 36 months of Ohio Works First benefit eligibility.

If you continue to be eligible, you have 11 months remaining.

After you have used up your 36 months, you might be eligible for additional months. See your caseworker.

If you disagree with this calculation, you can request a county conference and/or a state hearing. Please contact your caseworker or the Ohio Department of Human Services, Bureau of State Hearings, 30 East Broad Street, 32nd floor, Columbus, Ohio 43266-0423.

END

SEQ# 0000003 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000001
ODS 8599 (Rev. 12/97) 9999999999/ADCR/01 NOTICE TYPE: AD42N1

Client Notice: AD44N1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number: 00172-06

Date Implemented: 07/01/00

Last Date Revised: July, 2000

Description of Notice: This notice provides a final warning message for those recipients reaching 36 months used.

Assistance Group(s): OWF.

Hearing Rights: NO

Program ID: GCN093

Transaction ID:

Frequency: Monthly

Volume (est. monthly): 30,000

Form Number: DHS 8500

Notes:

WJKS 0301

0000001

FAIRFIELD COUNTY DEPT OF JOBS AND FAMILY SERVICES
P.O. BOX 890

LANCASTER OH 431300000

FINAL NOTICE
OWF "36-Month" Time Limit

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 7/05/2000
From: JACQUELINE K STOBBS
Phone: (740) 653-1701 Ext:

Worker ID: WJKS23
Case Number: 9999999999
AG Name: JANE DOE

FINAL WARNING

Only 2 more "Ohio Works First (OWF)" payments.

You will get an OWF payment for this month, 7/2000 . After that, you can only get 2 more payments

You will use up your 36-month limit if you get payments for the next 2 months. Your last payment will be for 9/2000.

No more payments after that unless your county approves a "hardship extension."

You will not get any OWF payments after 9/2000 unless you qualify for a "hardship extension" under your county's rules.

If you want to be considered for an extension: Talk with your caseworker. Ask for your county's rules about extensions.

You may keep getting other benefits after we stop your OWF payments.

You may keep getting other benefits such as Medical, Food Stamps, Child Day Care, PRC, Child Support Enforcement, etc. The 36-month limit does not apply to these other benefits. It only applies to OWF payments.

You must keep in touch with your caseworker to keep getting these other benefits.

For more information:

Please re-read the "Monthly Reminder" letters we have sent you. Ask your caseworker for details.

Client Notice: AD45N1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number: 00240-01

Date Implemented: 10/31/00

Last Date Revised: 10/31/00

Description of Notice: Anouncement of Medicaid reinstatement.

Assistance Group(s): OWF.

Hearing Rights: NO

Program ID: GCN093

Transaction ID:

Frequency: One-time

Volume (est. monthly): 170,000

Form Number: DHS 8500

Notes:

0000001

IMPORTANT NOTICE

OHIO FAMILY MEDICAL PROJECT
OHIO DEPARTMENT OF JOB AND FAMILY SERVICES
P.O. BOX 182399
COLUMBUS, OHIO 43272-3393

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 11/01/2000

Case Number: 9999999999
AG Name: JANE DOE

Ohio Family Medical Project

UNA NOTICIA IMPORTANTE ACERCA DEL SEGURO MÉDICO PARA FAMILIAS

Esta carta le informa como puede usted recibir 3 meses de seguro médico de Medicaid, sin compromiso alguno. Si usted necesita esta información en Español, llame al 1-800-324-8680.

IMPORTANT NEWS ABOUT FAMILY MEDICAL COVERAGE

from the Ohio Department of Job and Family Services (formerly the Ohio Department of Human Services)

We want to find people who lost Medicaid health coverage between November 1997 and April 2000. ***Some people should not have lost Medicaid health coverage back then, and may qualify to start getting Medicaid again.*** We also have new rules that allow more parents and children to get Medicaid health coverage.

Our records show that you lost Medicaid health coverage sometime between November 1, 1997 and April 30, 2000. We will send you a Medicaid health card that will be good for 3 months of medical coverage, ***no strings attached.*** During the 3 months we will see if you and your family can keep getting Medicaid health coverage.

What does this mean for you and your family?

1. We will send you a Medicaid health card that is good for 3 months of medical coverage, ***no strings attached.***

2. We will also send a letter like this to anyone else in your family who lost Medicaid sometime between November 1997 and April 2000. We will also send them a Medicaid health card that is good for 3 months of medical coverage. However, some members of your family may already be getting Medicaid coverage, like Healthy Start, and they will keep getting their usual Medicaid health coverage so they will not get a letter like this.

KEEP READING >>>>

3. Your 3-month Medicaid health card will cover all the medical services that Medicaid usually covers, like doctor visits, hospital services, prescriptions, dental and vision care. Your card will be good with any doctor, hospital, pharmacy or other medical provider who take Medicaid cards.

4. Remember there are ***no strings attached*** to the 3-month Medicaid health card. Please feel free to use it. You will not be asked to repay us for any services. If our review shows that you are not eligible for any more medical coverage, you still will not have to repay us for services you already received.

5. We may be able to pay some of your past medical bills if we find that you should not have lost your Medicaid health coverage.

6. You should get your 3-month Medicaid health card around January 1, 2001. You can use it right away.

7. When we send your 3-month Medicaid health card, we will also send you a short application form. We will send it in a different envelope than your card. We will use this application to see if your family can keep getting Medicaid after the 3 months are over. **It is very important to fill in the application and send it back immediately in the postage-paid envelope.**This way you should not have a break in your Medicaid coverage.

8. If your current mailing address is different than the address at the top of this letter, please fill out the enclosed Update Form and send it back to us in the enclosed postage-paid envelope. This way we can mail your 3-month Medicaid health card directly to you at your current mailing address. It is important to send back an Update Form for **each person** in your family who gets a letter like this if their current mailing address is different from the address listed on their letter.

9. If you do not want to get the 3-month Medicaid health card, fill out the enclosed Update Form and send it back to us in the enclosed postage-paid envelope. Remember to fill out and send back an Update Form for **each person** who does not want a card.

10. We will automatically send you a 3-month Medicaid health card unless you tell us you do not want it. If you want the 3-month Medicaid health card, you do not have to do anything except let us know if your current mailing address is different than the address at the top of this letter.

11. If you have any questions about this letter, you can contact your County Department of Job and Family Services (formerly the County Department of Human Services).

12. **CAUTION:** If you have already applied for Medicaid health coverage or any other type of assistance, please continue to follow-up with that application. **DO NOT STOP!**

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Ohio Family Medical Project
Update Form

Important: Return the information below, **only** if your current mailing address is different than at the top of this page **or** if you do not want to get the 3 months of Medicaid health coverage.

We will automatically send the 3-month Medicaid health card to the address that is on the top of this page if we do not hear from you.

Remember: You will get 3 months of Medicaid health coverage, **no strings attached.** It does not matter how much money you now earn. We will not ask you to pay back any money even if we find your family cannot keep getting Medicaid health coverage after the 3 months are over.

Please fill in the information below and mail this form to us in the enclosed postage-paid envelope ***only if*** your mailing address is different than the address at the top of this page ***or if*** you do not want your 3-month Medicaid health card. **Complete for each person who received this form.**

1. ☐ I have a different mailing address, please mail the 3-month Medicaid health card to the address below.

2. ☐ I do not want to receive the 3-month Medicaid health card. I understand that there are no strings attached, but I still don't want the Medicaid health card. Please do not send me any more mailings.

(please print)

( )

Name | Area Code | Telephone Number

Mailing Address

City | State | ZIP Code | County

Signature | Date

END

SEQ# 0306743
ODS 7900 (Rev. 8/00)
THIS SPACE FOR OFFICIAL USE ONLY
9999999999/MA C/01
PRINT SEQ. 0000001
NOTICE TYPE:AD45N1

Client Notice: AD45N2

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number: 00240-01

Date Implemented: 12/19/00

Last Date Revised: 12/19/00

Description of Notice: Medicaid reinstatement application packet.

Assistance Group(s): OWF.

Hearing Rights: NO

Program ID: GCN093

Transaction ID:

Frequency: One-time

Volume (est. monthly): 133,000

Form Number: DHS 8500

Notes:

0000001

IMPORTANT NOTICE

OHIO FAMILY MEDICAL PROJECT
OHIO DEPARTMENT OF JOB AND FAMILY SERVICES
P.O. BOX 182399
COLUMBUS, OHIO 43272-3393

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 11/01/2000

Case Number: 9999999999
AG Name: JANE DOE

OHIO FAMILY MEDICAL PROJECT
OHIO DEPARTMENT OF JOB AND FAMILY SERVICES

Application Packet

We are sending you this packet because you lost Medicaid health coverage sometime between November 1, 1997 and April 30, 2000. **Please read this packet carefully.** This is part of the Ohio Family Medical Project, encouraging families to apply for Healthy Start and Healthy Families. We sent you a letter about this in November 2000.

We are also sending you a Medicaid health card. You should get your card about the same time you get this letter. Your card is good for health coverage for January, February and March 2001. Please read the information on your Medicaid card.

You may apply to see if you and your family can keep getting Medicaid health coverage after March 31, 2001. We have new rules that help more families and children get Medicaid. Even if you have a job, you may still be eligible. If you are not eligible for Ohio Works First (OWF) cash payments, you can still be eligible for Medicaid health coverage.

To apply, please complete and return this application in the enclosed postage-paid envelope. This letter tells you how to complete the application.

If you return your application quickly, your family may be able to keep getting Medicaid after March 31, 2001 without a break in your health coverage. If you recently applied for Medicaid health coverage or any other type of assistance, please continue to follow-up with that application.

This packet contains:

1. Instructions for applying
2. Ohio Family Medical Project (Healthy Start Healthy Families) Application for Health Coverage
3. Rights and Responsibilities
4. Information on How to Get Payment of Past Medical Bills
5. Important Notice About Food Stamp Benefits
6. Postage-Paid Envelope

KEEP READING >>>>

INSTRUCTIONS FOR APPLYING

=>You will not have to come into our office for an interview.

=>Fill out the application.

=>If you need more space, please use a separate sheet of paper, and attach it to the application.

=>Attach proof of income.

=>Return your application to us in the postage-paid envelope.

Step 1: Fill out one application for your entire houesehold.

Fill out only one application even if we sent an application to other people in your household.
Fill in all sections of the application.

Here is special information about some of the sections on the application.

Sections A and B

* List everyone in your household, including yourself. If you need more space, please use a separate sheet of paper, and attach it to the application.
* Include everyone in your household even if they already get Medicaid health coverage (like Healthy Start, or Medicaid for the disabled).

Section C

* List each person in your household who has any earned or unearned income from any source (like wages, SSI checks, etc.).
* Attach proof of the income. Some examples are:
  * If you are employed - copies of pay stubs for the previous month, or most recent four week period, or a letter from your employer stating the amount of your monthly gross income.
  * If you are self employed - copy of IRS 1040 tax form with schedule C or F.
  * If you do not have proof now, you can send it to us later.

Section G

* We may be able to help you pay medical bills for the past three months. If you want us to see if you are eligible for help with these bills, please check the "Yes" box in this section and attach proof of income and medical bills for each of the past three months.

Step 2:
=> Sign and date the application.
=> Attach proof of income.
=> Attach copies of medical bills if you checked YES in section G.
=> Return to us in the enclosed postage-paid envelope.

Step 3: Read everything in this packet carefully. Keep this packet and a copy of the application for your records.

Step 4: Call us if you have any questions.

**=>Ohio Family Medical Project (1-888-221-1560) ***if you want information about the project * if you lose your Medicaid health card or * if you have not heard anything within 45 days after you sent in your application * if you move.
=>Medicaid Consumer Hotline (1-800-324-8680)if you have questions about how to complete the application.

Ohio Family Medical Project

Application for Health Coverage

NO FACE-TO-FACE INTERVIEW NECESSARY IF ONLY APPLYING FOR HEALTH COVERAGE

A separate application is required for cash assistance or food stamps.

Section A.

First Name of Person Completing Application | M.I. | Last Name

Street Address | Apt. #

City | State | Zip Code | County

Home Telephone ___-___-____ | Work Telephone ___-___-____ | Social Security Number (Optional) ___-__-____

Are you applying for health coverage for yourself? ☐Yes ☐No If YES, please be sure to include information about yourself below.

Section B. Please list everyone in the household. Please be sure to INCLUDE YOURSELF, if you are applying for health coverage. See instructions if you need more space.

Household Member #1

First Name | M.I. | Last Name

Is this person applying for HEALTH COVERAGE? ☐Yes ☐No | Is this person DISABLED? ☐Yes ☐No

U.S. Citizen ☐Yes ☐No | Race/Primary Language _____ | Social Security # ___-__-____

Sex (F/M) _____ | Date of Birth __/__/____ | Relationship To You: _____

Is this person pregnant? ☐Yes ☐No → If YES, # of Babies Due ____ → Due Date __/__/____

Household Member #2

First Name | M.I. | Last Name

Is this person applying for HEALTH COVERAGE? ☐Yes ☐No | Is this person DISABLED? ☐Yes ☐No

U.S. Citizen ☐Yes ☐No | Race/Primary Language _____ | Social Security # ___-__-____

Sex (F/M) _____ | Date of Birth __/__/____ | Relationship To You: _____

Is this person pregnant? ☐Yes ☐No → If YES, # of Babies Due ____ → Due Date __/__/____

Household Member #3

First Name | M.I. | Last Name

Is this person applying for HEALTH COVERAGE? ☐Yes ☐No | Is this person DISABLED? ☐Yes ☐No

U.S. Citizen ☐Yes ☐No | Race/Primary Language _____ | Social Security # ___-__-____

Sex (F/M) _____ | Date of Birth __/__/____ | Relationship To You: _____

Is this person pregnant? ☐Yes ☐No → If YES, # of Babies Due ____ → Due Date __/__/____

Household Member #4

First Name | M.I. | Last Name

Is this person applying for HEALTH COVERAGE? ☐Yes ☐No | Is this person DISABLED? ☐Yes ☐No

U.S. Citizen ☐Yes ☐No | Race/Primary Language _____ | Social Security # ___-__-____

Sex (F/M) _____ | Date of Birth __/__/____ | Relationship To You: _____

Is this person pregnant? ☐Yes ☐No → If YES, # of Babies Due ____ → Due Date __/__/____

Those who are interested in getting cash assistance through Ohio Works First, Food Stamps, or Medicaid for the aged, blind or disabled should contact the county department of job & family services.

KEEP READING >>>>

Section C. INCOME VERIFICATION - Complete the lines below for each person in your household who has earned or unearned income from any source, such as: wages, self-employment, social security, SSI, VA pension, workers compensation, alimony or child support. (Proof of income is required - See attached instructions)

Name	Employer or Income Source	Gross Amount	How Often Received
		$	
		$	

Section D. Do you PAY for someone to care for your children while you work or go to school? If YES, how much do you pay per child per week?

☐ Yes ☐ No $_____

Section E. Do you PAY child support? If YES, how much do you pay per week? (Child support payments you pay are not counted as part of your monthly income.)

☐ Yes ☐ No $_____

Section F. For each person in your household who has health insurance or a medical support order, please complete the lines below.

Insurance Company	Policy Number	Monthly Premium	Persons Covered	Please CIRCLE the services each policy covers.		
		$		Inpatient Hospital Ambulance	Doctor Visits Dental	Prescriptions Vision
		$		Inpatient Hospital Ambulance	Doctor Visits Dental	Prescriptions Vision

Section G. Would you like your eligibility for medical coverage looked at for the past 3 months? If YES, include income verification & medical expenses for each of the past 3 months. If you are found eligible, Medicaid may pay some or all of these medical expenses.

☐Yes ☐No

Section H. Would you like to get information on any of the following programs? (Please check.) The County Department of Job & Family Services (CDJFS) will contact you to help you apply.

☐Child Care ☐Child Support ☐Cash Assistance ☐Food Stamps

BY SIGNING THIS APPLICATION, I AGREE to give documentation and verification of information on this application. I understand I may be asked to give consent to the CDJFS to make whatever contacts are necessary to determine my eligibility.
I authorize any person who furnishes health care or medical supplies to give the Ohio Department of Job & Family Services any information related to the extent, duration, and scope of services provided under the Healthy Start, Healthy Families Medicaid program, and medical assistance programs. I also authorize the Ohio Department of Job & Family Services to exchange any information I have provided on this form, in order to enable the departments to determine my eligibility. I understand that this application will be considered without regard to race, color, sex, age, handicap, religion, national origin, or political belief.

Note: Your Social Security Number (SSN) on this application will be used for program reviews. These reviews tell the agency if program participation and outreach are taking place.

By my signature below, I affirm that to the best of my knowledge and belief the answers on this application are complete and correct. I have received a copy of and read all my rights and responsibilities or they have been read to me and I understand them. I understand that the law provides a penalty of fine or imprisonment (or both) for anyone convicted of accepting assistance he or she is not eligible for. I state under penalty of perjury that all of the information on this application is true and complete to the best of my knowledge.

SIGNATURES

_____ Person Applying Date: __/__/____

_____ Person Who Helped Complete This Form or Authorized Representative Date: __/__/____

Mailing Address (if different than address in Section A)

City State Zip Code County

Home Telephone ___ - ___ - ____ Work Telephone ___ - ___ - ____

Keep this page !

For Your Records

JFS 07236 [formerly ODHS 7236 (Rev 8/2000)]

YOUR RIGHTS & RESPONSIBILITIES

ODJFS assures that no person seeking participation in any program or person currently participating in a program shall have services denied/delayed or otherwise be discriminated against on the basis of race, color, religion, sex, national origin, disability, age, veteran status or sexual orientation.

YOU HAVE A RIGHT TO A STATE HEARING before the Ohio Department of Job & Family Services (ODJFS) if you are not satisfied with actions taken or decisions on your application. *When the local county department of job & family services receives your application, you will get a form that tells you how to ask for a hearing.*

YOU HAVE A RESPONSIBILITY:

TO REPORT CORRECT AND UPDATED INFORMATION. You are always responsible for giving complete and correct information about yourself and members of your household. You must include all supporting documentation and verifications with your completed application. You must report to the county department of job & family services, within 10 days, any change in your circumstances, such as: !You move to another address !Someone moves in with you or moves out !Any household member's income changes !Someone gets or loses a job !A child drops out of school or reaches the age of 19 !The end of your pregnancy and/or the birth of your child(ren).You should also report if anyone in your household, (including children) becomes disabled, is unable to work, or has applied for disability benefits (e.g., Social Security Disability, SSI, Workers Compensation, veteran's benefits.) You should report this information as soon as you become aware of it because it may help the person stay eligible for Medicaid benefits.

TO PROVIDE INFORMATION REGARDING CITIZENSHIP/ALIEN STATUS if you or members of your family are applying for Healthy Start, Healthy Families (Medicaid). Family members who are not U.S. citizens must provide the county department of job & family services with proof of alien status such as an alien registration card or re-entry permit. If you are applying for Healthy Start (Medicaid) for a child, but not for yourself, you are not required to supply proof about your citizenship.

TO GIVE MEDICAID ANY PAYMENTS YOU RECEIVE FROM OTHER HEALTH INSURANCE. You must tell the county department of job & family services about any other medical coverage you have or if someone else is legally responsible for paying medical bills for you or members of your family. Medicaid does not pay medical bills that a private health insurance company is supposed to pay. When you accept assistance from Medicaid, you must agree to give the Ohio Department of Job & Family Services your right to medical payments from a private medical insurance company while you have Medicaid. If you receive money directly from your medical insurance company to cover medical bills that Medicaid has paid for you or for anyone for whom you are legally responsible for, the Ohio Department of Job & Family Services has the right to get that money back from you.

TO COOPERATE WITH QUALITY CONTROL REVIEWS. Your name may be picked from a list of all the eligible cases in Ohio to see if you really are eligible for assistance based on the information you gave the Ohio Department of Job & Family Services. If your case is picked, you must cooperate by answering all the questions in order to continue to get medical coverage.

RELEASE OF INFORMATION ON SOCIAL SECURITY NUMBER FOR MEDICAID. You must give the county department of job & family services your Social Security Number (SSN) or apply for a SSN for each person seeking medical coverage. If you are applying for Medicaid for a child, you are not required to provide your own SSN, but we must have the child's SSN in order for the child to receive Medicaid. If you are applying for Medicaid for yourself, you must provide your SSN. The agency will use the SSN to verify income, eligibility, and the amount of medical assistance payments we will make on your behalf. Your SSN may also be matched with the records in other agencies such as the Social Security Administration. These matches may be done by computer or on an individual basis.Your social security number is given to medical insurance companies to see if there is coverage to pay all or part of your medical bills.Your social security number will be used during program reviews to make sure you are eligible for this program.

KEEP READING >>>>

OHIO FAMILY MEDICAL PROJECT

INFORMATION ON HOW TO GET PAYMENT OF PAST MEDICAL BILLS

If you lost Medicaid health coverage between November 1, 1997 and April 30, 2000, and you have medical bills (paid or unpaid), we may be able to help through the Ohio Family Medical Project.

If you have already paid these past medical bills, we may be able to reimburse you. If any of these past medical bills are still owed, we may be able to pay your provider directly.

To get payment of past medical bills, you must:

1) **Call the Ohio Family Medical Project at 1-888-221-1560 by March 31, 2001** to request a Past Medical Bills Application package. We will only accept requests for applications that are received by March 31, 2001.

2) Complete a separate Past Medical Bills application for each individual for whom you are requesting payment of past medical bills.

   * Attach proof of your household's income for the month that the medical services were received.

   * Attach proof that the medical services were received and paid, or that money is still owed.

3) Return the application and proof of income and medical bills to your local county department of job and family service by April 30, 2001.

NOTE: The past medical bills must be for medical services that Medicaid covers.

BEGIN GATHERING INFORMATION NOW!

* **Find copies of your bills.** We need to know when you got the services, the type of service and how much it cost. If you can't find the bills, ask for copies from your doctor, pharmacist, or other medical provider.

* **Proof of income** is needed to show what your household's income (earned and unearned) was during the month you received the medical service.

* **If you have paid the bills,** find receipts or canceled checks. We need proof of payment before we can consider reimbursing you.

* **If you have not paid the bills,** and you are found eligible, we will send a letter to your medical service provider. Your provider can then bill Medicaid for the services.

After we review your Past Medical Bills application, we will send you a letter letting you know if you are approved for payment or, if your request for payment of past medical bills has been denied and the reason why.

IMPORTANT NOTICE ABOUT FOOD STAMP BENEFITS

DO YOU NEED HELP PAYING FOR YOUR GROCERIES?

DID YOUR FOOD STAMPS RECENTLY STOP?

FOOD STAMPS CAN HELP YOU BUY MORE FOOD FOR YOUR FAMILY.

DID YOU KNOW???

You may be eligible for food stamps even if you are working a full-time job.

For example, a family of three with a full-time worker earning minimum wage can get up to $229 a month in food stamps. A family of three could earn up to $18,000 a year and still get food stamps.

****

The Food Stamp program provides families with the following services at no charge to them:

* Nutrition education to assist in buying and preparing nutritionally balanced meals.

* To replace paper coupons, Ohio Direction Cards to buy food.

****

FOR MORE INFORMATION:

To apply for food stamps, please contact your local department of job and family services. Ask to schedule an appointment. If you can't go to the office during the normal business day, ask about extended hours or Saturday hours. Families must meet certain guidelines in order to qualify for food stamps. Ask your caseworker for details.

END

Client Notice: AD45N3

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number: 00240-01

Date Implemented: 01/25/01

Last Date Revised: 01/25/01

Description of Notice: Past Medical benefits explanation.

Assistance Group(s): OWF.

Hearing Rights: NO

Program ID: GCN093

Transaction ID:

Frequency: One-time

Volume (est. monthly): 51,000

Form Number: DHS 8500

Notes:

0000001

IMPORTANT NOTICE

OHIO FAMILY MEDICAL PROJECT
OHIO DEPARTMENT OF JOB AND FAMILY SERVICES
P.O. BOX 182399
COLUMBUS, OHIO 43272-3393

JOHN DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 01/25/2001

Case Number: 9999999999
AG Name: JANE DOE

OHIO FAMILY MEDICAL PROJECT

INFORMATION ON HOW TO GET PAYMENT OF PAST MEDICAL BILLS

The Ohio Department of Job and Family Services has started the Ohio Family Medical Project. We want to find families who lost Medicaid coverage when they stopped getting an Ohio Works Firts check. Some families should not have lost Medicaid. You may have received medical services after losing Medicaid and then either paid for them yourself or still owe on them. It is possible that Medicaid should pay for these services.

Our records show that you lost Medicaid benefits sometime between November 1, 1997 and April 30, 2000. If you have already paid these past medical bills, we may be able to reimburse you. If any of these past medical bills are still owed, we may be able to pay your provioder directly.

To get payment of past medical bills, you must:

1) **Call the Ohio Family Medical Project at 1-888-221-1560 by March 31, 2001** to request a Past Medical Bills Application package. We will only accept requests for application packages that are received by March 31, 2001.

2) Complete a separate Past Medical Bills Application for each individual for whom you are requesting payment of past medical bills.

   * Attach proof of your household's income for the month that the medical services were received.

   * Attach proof that the medical services were received and paid, or that money is still owed.

3) Return the application and proof of income and medical bills to the Ohio Family Medical Project office by April 30, 2001.

NOTE: The past medical bills must be for medical services that Medicaid covers.

KEEP READING >>>>

BEGIN GATHERING INFORMATION NOW!

* **Find copies of your bills.** We need to know when you got the services, the type of service and how much it cost. If you can't find the bills, ask for copies from your doctor, pharmacist, or other medical provider.

* **Proof of income** is needed to show what your household's income (earned and unearned) was during the month you received the medical service.

* **If you have paid the bills,** find receipts or canceled checks. We need proof of payment before we can consider reimbursing you.

* **If you have not paid the bills,** and you are found eligible, we will send a letter to your medical service provider. Your provider can then bill Medicaid for the services.

After we review your Past Medical Bills Application, we will send you a letter letting you know if you are approved for payment or, if your request for reimbursement has been denied and the reason why.

If you have any questions regarding the Past Medical Bills application, call the Ohio Family Medical Project at 1-888-221-1560.

END

Client Notice: AD45N4

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number: 00240-01

Date Implemented: 01/22/01

Last Date Revised: 01/22/01

Description of Notice: Medicaid reinstatement reminder notice.

Assistance Group(s): OWF.

Hearing Rights: NO

Program ID: GCN093

Transaction ID:

Frequency: One-time

Volume (est. monthly): 133,000

Form Number: DHS 8500

Notes:

0000001

IMPORTANT NOTICE

OHIO FAMILY MEDICAL PROJECT
OHIO DEPARTMENT OF JOB AND FAMILY SERVICES
P.O. BOX 182399
COLUMBUS, OHIO 43272-3393

JOHN DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 12/20/2000

Case Number: 9999999999
AG Name: JANE DOE

OHIO FAMILY MEDICAL PROJECT
OHIO DEPARTMENT OF JOB AND FAMILY SERVICE

REMINDER LETTER

A short time ago, we mailed you a 3-month Medicaid health card and an application packet telling you how to get ongoing Medicaid health coverage. This information was sent out to you because you may have lost your Medicaid when your Ohio Works First cash ended between November 1, 1997 and April 30, 2000.

We have new rules that help more children and parents get Medicaid health coverage. You can even have a job and still be eligible for Medicaid health coverage and it is easier to apply.

REMEMBER YOU CAN:

- ☐ Use you 3-month Medicaid health card from January 1, 2001 through March 31, 2001. You will never have to repay us for any medical services you get with this card. There are no strings attached!
- ☐ Apply to keep getting Medicaid health coverage. Simply finish the short Healthy Start/Healthy Families application and attach your proof of income. Mail it right away!
- ☐ Use one application form to apply for your entire household.
- ☐ Call the Medicaid Consumer Hotline (1-800-324-8680) if you want help with your application Mail your application back to us right away. Use the postage-paid envelope that we mailed you with the application.
- ☐ Call the Ohio Family Medical Project (1-800-221-1560) to get a Past Medical Bill application. You can be reviewed for payment of old paid or unpaid medical bills. You must request this by March 31, 2001.
- ☐ Call the Ohio Family Medicaid Project center at 1-888-221-1560, Monday through Friday, 8:30 a.m. to 5:00 p.m. if you did not get your 3-month Medicaid health card or the application packet.

END

Client Notice: AD45N5

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number: 00240-01

Date Implemented: 01/22/01

Last Date Revised: 01/22/01

Description of Notice: Medicaid reinstatement termination notice.

Assistance Group(s): OWF.

Hearing Rights: NO

Program ID: GCN093

Transaction ID:

Frequency: One-time

Volume (est. monthly): 133,000

Form Number: DHS 8500

Notes:

0000001

IMPORTANT NOTICE

OHIO FAMILY MEDICAL PROJECT
OHIO DEPARTMENT OF JOB AND FAMILY SERVICES
P.O. BOX 182399
COLUMBUS, OHIO 43218-2399

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 3/01/2001 Case Number: 9999999999 AG Name: JANE DOE

Important Notice from the Ohio Family Medical Project: Your 3 months of Medicaid health coverage is ending!

We will **STOP** your **Medicaid** health coverage under the Ohio Family Medical Project on March 31, 2001. This only affects the three-month Medicaid card we sent you for January, February and March.

Reason: Medicaid health coverage under the Ohio Family Medical Project ends on March 31, 2001. We do not have enough information to decide whether you can keep getting Medicaid. We based this action on Public Assistance Letter #875 and Ohio Administrative Code rule 5101:1-38-01.

Ask for a State Hearing if you disagree or think we are making a mistake. Read the next page to find out how.

- If you have already applied for continued Medicaid health coverage through the Ohio Family Medical Project, you should receive an application receipt from the Ohio Family Medical Project. This receipt tells you that your application has been sent to your County Department of Job and Family Services for review. The county should notify you within 45 days from the date on your application receipt to let you know if you are approved or denied for continued Medicaid health coverage. If you do not agree with this decision, you can ask for a State Hearing.
- If you want to continue to get Medicaid health coverage after March 31, 2001, you must apply for Healthy Start, Healthy Families by completing the Ohio Family Medical Project application, or by calling the Ohio Medicaid Consumer Hotline at 1-800-324-8680 (a free call) for an application, or by applying at the County Department of Job and Family Services.
- If you did not apply for continued Medicaid health coverage, your Medicaid health care benefits will still end on March 31, 2001. If you do not agree with this decision, you have the right to ask for a State Hearing.
- If you have already been approved for Healthy Start, Healthy Families you will get your regular Medicaid card beginning April 1, 2001.

KEEP READING >>>>

AG Name:	Case Number:	Mailing Date:
JANE DOE	9999999999	03/01/2001

This "Important 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.

Ask for a State Hearing if you want to appeal.

Ask for a State Hearing if you disagree or think we are making a mistake. At the state hearing, you can explain your reasons. We will explain our reasons. A hearing officer from the Ohio Department of Job and Family Services will decide who is right.

We must get your request for a State Hearing by the deadline.

- **The first deadline is 3/21/2001. We will not stop your Medicaid before your hearing if we get your hearing request by the first deadline.**
- The final deadline is 5/31/2001. If we get your hearing request after the first deadline, we will stop your Medicaid before the hearing. You may still have a hearing but only if we get your request by the final deadline.

Please use the next page ("State Hearing Request") to ask for a State Hearing. Save all the other pages of this notice.

Someone else may help you (a lawyer, social worker, friend, relative, etc.). Someone else may request a hearing for you and come to the hearing with you.

You can also get information about free legal services. For free legal help call the Ohio State Legal Services Association at 1-800-589-5888 (a free call).

KEEP READING >>>

AG Name:	Case Number:	Mailing Date:
JANE DOE	9999999999	03/01/2001

STATE HEARING REQUEST

Get this to us by the deadline to ask for a State Hearing!

OHIO FAMILY MEDICAL PROJECT

STEP 1 ***Fill in the blanks, then sign.***

I want a State Hearing. I think my Medicaid eligibility should continue because:

_____

_____

_____

_____

☐ I also want a County Conference. (A county conference is a meeting with you and staff from our County Department of Job and Family Services.)

My signature:_____ Date:_____ Phone: (___)_____

STEP 2 ***(Optional): Complete this if someone else has already agreed to represent you (a lawyer, social worker, friend, relative, etc.). If someone later agrees to represent you, tell us then.***

My authorized representative is:
Name:_____Phone: (___)_____
Address:_____ Fax: (___)_____
_____ E-mail:_____

STEP 3 ***Choose one of these ways to send this request to us. We must get this request by the deadline!***

MAIL: Mail only this page. Follow the steps on the back of this page.

FAX: Fax only this side of this page to 614-728-9574 (ODJFS Bureau of State Hearings).

E-MAIL: E-mail to "bsh@odjfs.state.oh.us". Please include all the information requested in Steps 1 and 2; and all the information from box at the top of this notice (AG Name, Case Number and Mailing Date).

VISIT OR PHONE YOUR CASEWORKER: It is better to ask for a hearing by using mail, fax or e-mail. You may visit or phone your caseworker. Ask for a "State Hearing." Only you may phone. Take all pages of this notice if you visit your caseworker. Mention this notice if you phone.

KEEP READING >>>

Mailing Steps:
(1) Fold this page only along the dotted lines.
(2) Tape or staple after folding.

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO 5249 COLUMBUS OH

POSTAGE WILL BE PAID BY ADDRESSEE

OHIO DEPT OF JOB AND FAMILY SERVICES
BUREAU OF STATE HEARINGS
P.O. BOX 182825
COLUMBUS, OHIO 43272-5376

END

PRINT SEQ. 0000001

Client Notice: AE01-A1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	July, 2000

Description of Notice:	Approval of Medical Assistance with no retroactive benefits
Assistance Categories:	All Medical Assistance except MA-L, MA-O, MA-US, MA-Z
Hearing Rights:	Yes
Program ID:	GAE501
Transaction ID:	Authorization
Frequency:	Daily
Volume (est. monthly):	19,546
Form Number:	DHS 8500
Notes:	

0000064 WMLH 0066

FAIRFIELD COUNTY DEPT OF HUMAN SERVICES
P.O. BOX 890

LANCASTER OH 431300000

IMPORTANT NOTICE

JANE DOE
111 MAIN ST.

ANYWHERE, USA 11111-1111

Mailing Date: 05/13/1998
From: MISTY L HUSTON
Phone: (614) 653-1701 Ext: 6808

Worker ID: WMLH23
Case Number: 1111111111
AG Name: JANE DOE

Dear JANE DOE

Your HEALTHY START application dated 01/26/1998 has been APPROVED effective 06/01/1998.

The people affected by this action are:
JANE D (INELIGIBLE) JANE D (ELIGIBLE)

Reason: ALL ELIGIBILITY REQUIREMENTS HAVE BEEN MET
We based this action on OHIO PUBLIC ASSISTANCE MANUAL Section 01020

RC: 091 MA P 1 A1

KEEP READING >>>

SEQ# 0000047 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000064
DHS 8500 (Rev. 02/98) 1111111111/MA P/01 NOTICE TYPE: AE01A1

AG Name:	Case Number:	Mailing Date:
JANE DOE	1111111111	05/13/1998

This "Important 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.

Ask for a State Hearing if you want to appeal.

Ask for a State Hearing if you disagree with what we are doing or think we are making a mistake. At the state hearing, you can explain your reasons. We will explain our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

We must get your request for a State Hearing by the deadline: 10/10/2000.

Please use the next page ("State Hearing Request") to ask for a State Hearing. Save all the other pages of this notice.

Someone else may help you (a lawyer, social worker, friend, relative, etc.). Someone else may request a hearing for you and come to the hearing with you.

You can also get information about free legal services. For free legal help call the Ohio State Legal Services Association at 1-800-589-5888 (a free call).

AG Name:	Case Number:	Mailing Date:
JANE DOE	1111111111	05/13/1998

STATE HEARING REQUEST

Get this to us by the deadline to ask for a State Hearing!

STEP 1 *Check all the boxes that apply, then sign.*

I want a State Hearing. I am most concerned about (optional):

- ☐ Checks or cash assistance (OWF or DA)
- ☐ Food Stamps
- ☐ Medical assistance (Medicaid, Medicare, LIF, Healthy Start, DA Medical, spenddown, nursing homes, QMB, SLMB, etc.)
- ☐ PRC
- ☐ Other (please explain):_____

(examples: child day care, child support, overpayments, etc.)

☐ I also want a County Conference. (A county conference is a meeting with you and staff from our county department of human services.)

My signature:_____ Date:_____ Phone: (___)_____

STEP 2 *You must complete this part if someone else is helping you with your case (a lawyer, social worker, friend, relative, etc.)*

My authorized representative is:

Name:_____Phone: (___)_____

Address:_____ Fax: (___)_____

_____ E-mail:_____

STEP 3 *Choose one of these ways to send this request to us. We must get this request by the deadline!*

MAIL: Mail only this page. Follow the steps on the back of this page.

FAX: Fax only this side of this page to 614-728-9574 (ODHS Bureau of State Hearings).

E-MAIL: E-mail to "bsh@odhs.state.oh.us". Please include all the information requested in Steps 1 and 2; and all the information from box at the top of this notice (AG Name, Case Number and Mailing Date).

VISIT OR PHONE YOUR CASEWORKER: It is better to ask for a hearing by using mail, fax or e-mail. You may visit or phone your caseworker. Ask for a "State Hearing." Only you may phone. Take all pages of this notice if you visit your caseworker. Mention this notice if you phone.

KEEP READING >>>

Mailing Steps:
(1) Fold this page only along the dotted lines.
(2) Tape or staple after folding.

JANE DOE
111 MAIN ST OH 99999-9999

ANYWHERE OH 99999-9999

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO 5249 COLUMBUS OH

POSTAGE WILL BE PAID BY ADDRESSEE

OHIO DEPARTMENT OF HUMAN SERVICES
BUREAU OF STATE HEARINGS
P.O. BOX 182825
COLUMBUS, OHIO 43272-5376

END

PRINT SEQ. 0000668

Client Notice: AE01-A2

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	July, 2000

Description of Notice:	Approval of Food Stamps with prorated intitial benefits
Assistance Categories:	FS
Hearing Rights:	Yes
Program ID:	GAE501
Transaction ID:	Authorization
Frequency:	Daily
Volume (est. monthly):	36,000
Form Number:	DHS 8500

Notes:

WJMK 0303

0000668

IMPORTANT NOTICE

FAIRFIELD COUNTY DEPT OF JOBS AND FAMILY SERVICES
P.O. BOX 890

LANCASTER OH 431300000

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 07/10/2000
From: JEANNE M KELL
Phone: (614) 653-1701 Ext:

Worker ID: WJMK23
Case Number: 9999999999
AG Name: JANE DOE

Dear JANE DOE

We APPROVED your FOOD STAMPS application of 05/01/2000. You can get $349 for 07/2000. You must add these food stamps to your Ohio Direction EBT Card by 07/31/2000 . You can get $349 each month for 08/01/2000 through 08/31/2000. You must add each month's food stamps to your Card by the end of each month.

WARNING! You will lose any food stamps that you fail to add to your Ohio Direction EBT Card by the deadline. After you add food stamps to your Card you may use them whenever you wish.

Contact your county Direction Card EBT office: to get your plastic Card; or to get help with your Card or PIN; or to report your Card lost, stolen or damaged. Call the Helpline (1-800-944-3273) to check your account balance; or to change the location where you add food stamps to your Card.

The people affected by this action are:
JOHN D (ELIGIBLE) JANE D (ELIGIBLE) JANE D (ELIGIBLE) JOHN D (ELIGIBLE) JOHN D (ELIGIBLE) JOHN D (ELIGIBLE)

Reason: YOU ARE ELIGIBLE UNDER ALL THE RULES
We based this action on OHIO ADMINISTRATIVE CODE, Rule 5101:4-5-07

RC: 091 FS 3 A2

KEEP READING >>>

SEQ# 0000030 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000668
DHS 8500 (Rev. 02/98) 9999999999/FS /03 NOTICE TYPE: AE01A2

AG Name:	Case Number:	Mailing Date:
JANE DOE	9999999999	07/10/2000

This "Important 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.

Ask for a State Hearing if you want to appeal.

Ask for a State Hearing if you disagree with what we are doing or think we are making a mistake. At the state hearing, you can explain your reasons. We will explain our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

We must get your request for a State Hearing by the deadline: 10/10/2000.

Please use the next page ("State Hearing Request") to ask for a State Hearing. Save all the other pages of this notice.

Someone else may help you (a lawyer, social worker, friend, relative, etc.). Someone else may request a hearing for you and come to the hearing with you.

You can also get information about free legal services. For free legal help call the Ohio State Legal Services Association at 1-800-589-5888 (a free call).

KEEP READING >>>

AG Name:	Case Number:	Mailing Date:
JANE DOE	9999999999	07/10/2000

STATE HEARING REQUEST

Get this to us by the deadline to ask for a State Hearing!

STEP 1 *Check all the boxes that apply, then sign.*

I want a State Hearing. I am most concerned about (optional):

- ☐ Checks or cash assistance (OWF or DA)
- ☐ Food Stamps
- ☐ Medical assistance (Medicaid, Medicare, LIF, Healthy Start, DA Medical, spenddown, nursing homes, QMB, SLMB, etc.)
- ☐ PRC
- ☐ Other (please explain):_____

(examples: child day care, child support, overpayments, etc.)

☐ I also want a County Conference. (A county conference is a meeting with you and staff from our county department of human services.)

My signature:_____ Date:_____ Phone: (___)_____

STEP 2 *You must complete this part if someone else is helping you with your case (a lawyer, social worker, friend, relative, etc.)*

My authorized representative is:

Name:_____Phone: (___)_____

Address:_____ Fax: (___)_____

_____ E-mail:_____

STEP 3 *Choose one of these ways to send this request to us. We must get this request by the deadline!*

MAIL: Mail only this page. Follow the steps on the back of this page.

FAX: Fax only this side of this page to 614-728-9574 (ODHS Bureau of State Hearings).

E-MAIL: E-mail to "bsh@odhs.state.oh.us". Please include all the information requested in Steps 1 and 2; and all the information from box at the top of this notice (AG Name, Case Number and Mailing Date).

VISIT OR PHONE YOUR CASEWORKER: It is better to ask for a hearing by using mail, fax or e-mail. You may visit or phone your caseworker. Ask for a "State Hearing." Only you may phone. Take all pages of this notice if you visit your caseworker. Mention this notice if you phone.

KEEP READING >>>

Mailing Steps:
(1) Fold this page only along the dotted lines.
(2) Tape or staple after folding.

JANE DOE
111 MAIN ST OH 99999-9999

ANYWHERE OH 99999-9999

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO 5249 COLUMBUS OH

POSTAGE WILL BE PAID BY ADDRESSEE

OHIO DEPARTMENT OF HUMAN SERVICES
BUREAU OF STATE HEARINGS
P.O. BOX 182825
COLUMBUS, OHIO 43272-5376

END

PRINT SEQ. 0000668

Client Notice: AE01-A3

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	July, 2000

Description of Notice:	Approval of Medical Assistance with retroactive benefits
Assistance Categories:	All medical assistance except MA-L, MA-O, MA-US, MA-Z
Hearing Rights:	Yes
Program ID:	GAE501
Transaction ID:	Authorization
Frequency:	Daily
Volume (est. monthly):	30,000
Form Number:	DHS 8500

Notes:

WLJN 0065

0000001

IMPORTANT NOTICE

FAIRFIELD COUNTY DEPT OF HUMAN SERVICES
P.O. BOX 890

LANCASTER OH 431300000

JANE DOE
11 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 03/11/1999
From: LINDA J THOMAS
Phone: (614) 653-1701 Ext:

Worker ID: WLJN23
Case Number: 9999999999
AG Name: JANE DOE

Dear JANE DOE

We APPROVED your HEALTHY START application of 02/04/1999. Your benefits start 02/01/1999. You will get benefits for:02/1999, 03/1999, and each month after that.
If you have paid for medical services while eligible for Medicaid, you may be able to get your money back. For information call the Medicaid Consumer Hotline at 1-800-324-8680 or TDD 1-800-292-3572.

The people affected by this action are:
JANE D (ELIGIBLE)

Reason: ALL ELIGIBILITY REQUIREMENTS HAVE BEEN MET
We based this action on OHIO ADMINISTRATIVE CODE, Rule 01020

RC: 091 MA P 1 A3

KEEP READING >>>

SEQ# 0000001 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000001
DHS 8500 (Rev. 02/98) 9999999999/MA P/01 NOTICE TYPE: AE01A3

AG Name:	Case Number:	Mailing Date:
JANE DOE	9999999999	03/11/1999

This "Important 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.

Ask for a State Hearing if you want to appeal.

Ask for a State Hearing if you disagree with what we are doing or think we are making a mistake. At the state hearing, you can explain your reasons. We will explain our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

We must get your request for a State Hearing by the deadline: 06/09/1999.

Please use the next page ("State Hearing Request") to ask for a State Hearing. Save all the other pages of this notice.

Someone else may help you (a lawyer, social worker, friend, relative, etc.). Someone else may request a hearing for you and come to the hearing with you.

You can also get information about free legal services. For free legal help call the Ohio State Legal Services Association at 1-800-589-5888 (a free call).

AG Name:	Case Number:	Mailing Date:
JANE DOE	9999999999	03/11/1999

STATE HEARING REQUEST

Get this to us by the deadline to ask for a State Hearing!

STEP 1 *Check all the boxes that apply, then sign.*

I want a State Hearing. I am most concerned about (optional):

- ☐ Checks or cash assistance (OWF or DA)
- ☐ Food Stamps
- ☐ Medical assistance (Medicaid, Medicare, LIF, Healthy Start, DA Medical, spenddown, nursing homes, QMB, SLMB, etc.)
- ☐ PRC
- ☐ Other (please explain):_____

(examples: child day care, child support, overpayments, etc.)

☐ I also want a County Conference. (A county conference is a meeting with you and staff from our county department of human services.)

My signature:_____ Date:_____ Phone: (___)_____

STEP 2 *You must complete this part if someone else is helping you with your case (a lawyer, social worker, friend, relative, etc.)*

My authorized representative is:

Name:_____Phone: (___)_____

Address:_____ Fax: (___)_____

_____ E-mail:_____

STEP 3 *Choose one of these ways to send this request to us. We must get this request by the deadline!*

MAIL: Mail only this page. Follow the steps on the back of this page.

FAX: Fax only this side of this page to 614-728-9574 (ODHS Bureau of State Hearings).

E-MAIL: E-mail to "bsh@odhs.state.oh.us". Please include all the information requested in Steps 1 and 2; and all the information from box at the top of this notice (AG Name, Case Number and Mailing Date).

VISIT OR PHONE YOUR CASEWORKER: It is better to ask for a hearing by using mail, fax or e-mail. You may visit or phone your caseworker. Ask for a "State Hearing." Only you may phone. Take all pages of this notice if you visit your caseworker. Mention this notice if you phone.

KEEP READING >>>

Mailing Steps:
(1) Fold this page only along the dotted lines.
(2) Tape or staple after folding.

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO 5249 COLUMBUS OH

POSTAGE WILL BE PAID BY ADDRESSEE

OHIO DEPARTMENT OF HUMAN SERVICES
BUREAU OF STATE HEARINGS
P.O. BOX 182825
COLUMBUS, OHIO 43272-5376

END

PRINT SEQ. 0000001

Client Notice: AE01-A4

A client notice name is composed of th **Notice Type**, which is four characters and a n**Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	July, 2000

Description of Notice:	Approval of ADC, RSS or DA with retroactive benefits
Assistance Categories:	ADC, GA-A, MA-O
Hearing Rights:	Yes
Program ID:	GAE501
Transaction ID:	Authorization
Frequency:	Daily
Volume (est. monthly):	14,000
Form Number:	DHS 8500

Notes:

WMLH 0066

0000002

IMPORTANT NOTICE

FAIRFIELD COUNTY DEPT OF HUMAN SERVICES
P.O. BOX 890

LANCASTER OH 431300000

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 03/11/1999
From: MISTY L HUSTON
Phone: (614) 653-1701 Ext: 6808

Worker ID: WMLH23
Case Number: 9999999999
AG Name: JANE DOE

Dear JANE DOE

We APPROVED your OHIO WORKS FIRST (OWF) application of 02/25/1999. Your benefits start 03/01/1999. You will get $362 for 03/01/1999 through 03/31/1999. You will get $362 each month after that.

The people affected by this action are:
JANE D (ELIGIBLE) JANE D (ELIGIBLE) JOHN D (ELIGIBLE)

Reason: ALL ELIGIBILITY REQUIREMENTS HAVE BEEN MET
We based this action on OHIO ADMINISTRATIVE CODE, Rule 5101:1-2-10

RC: 091 ADCR 1 A4

KEEP READING >>>

SEQ# 0000045 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000002
DHS 8500 (Rev. 02/98) 9999999999/ADCR/01 NOTICE TYPE: AE01A4

AG Name:	Case Number:	Mailing Date:
JANE DOE	9999999999	03/11/1999

This "Important 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.

Ask for a State Hearing if you want to appeal.

Ask for a State Hearing if you disagree with what we are doing or think we are making a mistake. At the state hearing, you can explain your reasons. We will explain our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

We must get your request for a State Hearing by the deadline: 06/09/1999.

Please use the next page ("State Hearing Request") to ask for a State Hearing. Save all the other pages of this notice.

Someone else may help you (a lawyer, social worker, friend, relative, etc.). Someone else may request a hearing for you and come to the hearing with you.

You can also get information about free legal services. For free legal help call the Ohio State Legal Services Association at 1-800-589-5888 (a free call).

AG Name:	Case Number:	Mailing Date:
JANE DOE	9999999999	03/11/1999

STATE HEARING REQUEST

Get this to us by the deadline to ask for a State Hearing!

STEP 1 *Check all the boxes that apply, then sign.*

I want a State Hearing. I am most concerned about (optional):

- ☐ Checks or cash assistance (OWF or DA)
- ☐ Food Stamps
- ☐ Medical assistance (Medicaid, Medicare, LIF, Healthy Start, DA Medical, spenddown, nursing homes, QMB, SLMB, etc.)
- ☐ PRC
- ☐ Other (please explain):_____

(examples: child day care, child support, overpayments, etc.)

☐ I also want a County Conference. (A county conference is a meeting with you and staff from our county department of human services.)

My signature:_____ Date:_____ Phone: (___)_____

STEP 2 *You must complete this part if someone else is helping you with your case (a lawyer, social worker, friend, relative, etc.)*

My authorized representative is:

Name:_____Phone: (___)_____

Address:_____ Fax: (___)_____

_____ E-mail:_____

STEP 3 *Choose one of these ways to send this request to us. We must get this request by the deadline!*

MAIL: Mail only this page. Follow the steps on the back of this page.

FAX: Fax only this side of this page to 614-728-9574 (ODHS Bureau of State Hearings).

E-MAIL: E-mail to "bsh@odhs.state.oh.us". Please include all the information requested in Steps 1 and 2; and all the information from box at the top of this notice (AG Name, Case Number and Mailing Date).

VISIT OR PHONE YOUR CASEWORKER: It is better to ask for a hearing by using mail, fax or e-mail. You may visit or phone your caseworker. Ask for a "State Hearing." Only you may phone. Take all pages of this notice if you visit your caseworker. Mention this notice if you phone.

KEEP READING >>>

Mailing Steps:
(1) Fold this page only along the dotted lines.
(2) Tape or staple after folding.

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO 5249 COLUMBUS OH

POSTAGE WILL BE PAID BY ADDRESSEE

OHIO DEPARTMENT OF HUMAN SERVICES
BUREAU OF STATE HEARINGS
P.O. BOX 182825
COLUMBUS, OHIO 43272-5376

END

PRINT SEQ. 0000002

Client Notice: AE01-A5

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	July, 2000

Description of Notice:	Approval of ADC, RSS or DA with no retroactive benefits
Assistance Categories:	ADC, GA-A, MA-O
Hearing Rights:	Yes
Program ID:	GAE501
Transaction ID:	Authorization
Frequency:	Daily
Volume (est. monthly):	4,200
Form Number:	DHS 8500
Notes:	

WBSD 0032

0000006

IMPORTANT NOTICE

FAIRFIELD COUNTY DEPT OF HUMAN SERVICES
P.O. BOX 890

LANCASTER OH 431300000

JOHN DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 03/11/1999
From: BARBARA D DENNIS
Phone: (614) 653-1701 Ext:

Worker ID: WBSD23
Case Number: 9999999999
AG Name: JOHN DOE

Dear JOHN DOE

We APPROVED your OHIO WORKS FIRST (OWF) application of 01/21/1999. Your benefits start 04/01/1999. You will get $216 each month.

The people affected by this action are:
JOHN D (ELIGIBLE)

Reason: ALL ELIGIBILITY REQUIREMENTS HAVE BEEN MET
We based this action on OHIO ADMINISTRATIVE CODE, Rule 5101:1-2-10

RC: 091 ADCR 3 A5

KEEP READING >>>

SEQ# 0000036 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000006
DHS 8500 (Rev. 02/98) 9999999999/ADCR/03 NOTICE TYPE: AE01A5

AG Name:	Case Number:	Mailing Date:
JOHN DOE	9999999999	03/11/1999

This "Important 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.

Ask for a State Hearing if you want to appeal.

Ask for a State Hearing if you disagree with what we are doing or think we are making a mistake. At the state hearing, you can explain your reasons. We will explain our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

We must get your request for a State Hearing by the deadline: 07/06/1999.

Please use the next page ("State Hearing Request") to ask for a State Hearing. Save all the other pages of this notice.

Someone else may help you (a lawyer, social worker, friend, relative, etc.). Someone else may request a hearing for you and come to the hearing with you.

You can also get information about free legal services. For free legal help call the Ohio State Legal Services Association at 1-800-589-5888 (a free call).

AG Name:	Case Number:	Mailing Date:
JOHN DOE	9999999999	03/11/1999

STATE HEARING REQUEST

Get this to us by the deadline to ask for a State Hearing!

STEP 1 *Check all the boxes that apply, then sign.*

I want a State Hearing. I am most concerned about (optional):

- ☐ Checks or cash assistance (OWF or DA)
- ☐ Food Stamps
- ☐ Medical assistance (Medicaid, Medicare, LIF, Healthy Start, DA Medical, spenddown, nursing homes, QMB, SLMB, etc.)
- ☐ PRC
- ☐ Other (please explain):_____

(examples: child day care, child support, overpayments, etc.)

☐ I also want a County Conference. (A county conference is a meeting with you and staff from our county department of human services.)

My signature:_____ Date:_____ Phone: (___)_____

STEP 2 *You must complete this part if someone else is helping you with your case (a lawyer, social worker, friend, relative, etc.)*

My authorized representative is:

Name:_____Phone: (___)_____

Address:_____ Fax: (___)_____

_____ E-mail:_____

STEP 3 *Choose one of these ways to send this request to us. We must get this request by the deadline!*

MAIL: Mail only this page. Follow the steps on the back of this page.

FAX: Fax only this side of this page to 614-728-9574 (ODHS Bureau of State Hearings).

E-MAIL: E-mail to "bsh@odhs.state.oh.us". Please include all the information requested in Steps 1 and 2; and all the information from box at the top of this notice (AG Name, Case Number and Mailing Date).

VISIT OR PHONE YOUR CASEWORKER: It is better to ask for a hearing by using mail, fax or e-mail. You may visit or phone your caseworker. Ask for a "State Hearing." Only you may phone. Take all pages of this notice if you visit your caseworker. Mention this notice if you phone.

KEEP READING >>>

Mailing Steps:
(1) Fold this page only along the dotted lines.
(2) Tape or staple after folding.

JOHN DOE
111 MAIN ST

ANYWHERE OH 99999-9999

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO 5249 COLUMBUS OH

POSTAGE WILL BE PAID BY ADDRESSEE

OHIO DEPARTMENT OF HUMAN SERVICES
BUREAU OF STATE HEARINGS
P.O. BOX 182825
COLUMBUS, OHIO 43272-5376

END

PRINT SEQ. 0000006

Client Notice: AE01-A6

A client notice name is composed of th **Notice Type**, which is four characters and a n**Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	July, 2000

Description of Notice:	Approval of Medicaid with spend down liability
Assistance Categories:	MA-A, MA-B, MA-D
Hearing Rights:	Yes
Program ID:	GAE501
Transaction ID:	Authorization
Frequency:	Daily
Volume (est. monthly):	2,300
Form Number:	DHS 8500

Notes:

WMAM 0062

0000004

IMPORTANT NOTICE

FAIRFIELD COUNTY DEPT OF HUMAN SERVICES
P.O. BOX 890

LANCASTER OH 431300000

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 04/05/1999
From: MARGARET A MOHLER
Phone: (614) 653-1701 Ext: 6808

Worker ID: WMAM23
Case Number: 9999999999
AG Name: JANE DOE

Dear JANE DOE

Your MEDICAID FOR THE DISABLED application dated 03/23/1999 has been APPROVED. Your income is $63 over the Medicaid income level. Therefore, you have been found eligible for a program called Medicaid spenddown. You must incur (run up) $63 in medical costs, which are not subject to payment by a third party, each month before your Medicaid card can be released to you. After you submit verification to your caseworker that you have incurred (whether or not paid) your monthly Medicaid spenddown amount, your monthly Medicaid card will be immediately issued to you.The effective date of your Medicaid coverage will be the day on which you reach spenddown level.
If you have paid for medical services while eligible for Medicaid, you may be able to get your money back. For information call the Medicaid Consumer Hotline at 1-800-324-8680 or TDD 1-800-292-3572.

The people affected by this action are:
JANE D (ELIGIBLE) JOHN D (INELIGIBLE) JOHN D (INELIGIBLE)

Reason: FAILURE TO MEET SPENDDOWN LIABILITY
We based this action on OHIO ADMINISTRATIVE CODE, Rule 07467

Reason: ALL ELIGIBILITY REQUIREMENTS HAVE BEEN MET
We based this action on OHIO ADMINISTRATIVE CODE, Rule 01020

RC: 403 091 MA D 1 A6

KEEP READING >>>

SEQ# 0000032 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000004
DHS 8500 (Rev. 02/98) 9999999999/MA D/01 NOTICE TYPE: AE01A6

AG Name:	Case Number:	Mailing Date:
JANE DOE	9999999999	04/05/1999

This "Important 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.

Ask for a State Hearing if you want to appeal.

Ask for a State Hearing if you disagree with what we are doing or think we are making a mistake. At the state hearing, you can explain your reasons. We will explain our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

We must get your request for a State Hearing by the deadline: 07/06/1999.

Please use the next page ("State Hearing Request") to ask for a State Hearing. Save all the other pages of this notice.

Someone else may help you (a lawyer, social worker, friend, relative, etc.). Someone else may request a hearing for you and come to the hearing with you.

You can also get information about free legal services. For free legal help call the Ohio State Legal Services Association at 1-800-589-5888 (a free call).

AG Name:	Case Number:	Mailing Date:
JANE DOE	9999999999	04/05/1999

STEP 1 *Check all the boxes that apply, then sign.*

I want a State Hearing. I am most concerned about (optional):

- ☐ Checks or cash assistance (OWF or DA)
- ☐ Food Stamps
- ☐ Medical assistance (Medicaid, Medicare, LIF, Healthy Start, DA Medical, spenddown, nursing homes, QMB, SLMB, etc.)
- ☐ PRC
- ☐ Other (please explain):_____

(examples: child day care, child support, overpayments, etc.)

☐ I also want a County Conference. (A county conference is a meeting with you and staff from our county department of human services.)

My signature:_____ Date:_____ Phone: (___)_____

STEP 2 *You must complete this part if someone else is helping you with your case (a lawyer, social*

My authorized representative is:
Name:_____Phone: (___)_____
Address:_____ Fax: (___)_____
_____ E-mail:_____

STEP 3 *Choose one of these ways to send this request to us. We must get this request by the deadline!*

MAIL: Mail only this page. Follow the steps on the back of this page.

FAX: Fax only this side of this page to 614-728-9574 (ODHS Bureau of State Hearings).

E-MAIL: E-mail to "bsh@odhs.state.oh.us". Please include all the information requested in Steps 1 and 2; and all the information from box at the top of this notice (AG Name, Case Number and Mailing Date).

VISIT OR PHONE YOUR CASEWORKER: It is better to ask for a hearing by using mail, fax or e-mail. You may visit or phone your caseworker. Ask for a "State Hearing." Only you may phone. Take all pages of this notice if you visit your caseworker. Mention this notice if you phone.

KEEP READING >>>

SEQ# 0000032 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000004
9999999999/MA D/01 NOTICE TYPE: AE01A6

Mailing Steps:
(1) Fold this page only along the dotted lines.
(2) Tape or staple after folding.

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO 5249 COLUMBUS OH

POSTAGE WILL BE PAID BY ADDRESSEE

OHIO DEPARTMENT OF HUMAN SERVICES
BUREAU OF STATE HEARINGS
P.O. BOX 182825
COLUMBUS, OHIO 43272-5376

END

PRINT SEQ. 0000004

Client Notice: AE01-A7

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	July, 2000

Description of Notice:	Approval of Medicaid with nursing home patient liability
Assistance Categories:	MA-A, MA-B, MA-D
Hearing Rights:	Yes
Program ID:	GAE501
Transaction ID:	Authorization
Frequency:	Daily
Volume (est. monthly):	200
Form Number:	DHS 8500

Notes:

WMHJ 1044

0000012

IMPORTANT NOTICE

RICHLAND COUNTY DEPT OF HUMAN SERVICES
171 PARK AVENUE EAST
P.O. BOX 188
MANSFIELD OH 449010000

JANE DEO
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 04/05/1999
From: M. H JORDAN
Phone: (419) 774-5319 Ext: 5319

Worker ID: WMHJ70
Case Number: 9999999999
AG Name: JANE DOE

Dear JANE DOE

Your MEDICAID FOR THE AGED application dated 01/29/1999 has been APPROVED effective 05/01/1999. You are responsible for a monthly patient liability of $102.
If you have paid for medical services while eligible for Medicaid, you may be able to get your money back. For information call the Medicaid Consumer Hotline at 1-800-324-8680 or TDD 1-800-292-3572.

The people affected by this action are:
JANE D (ELIGIBLE)

Reason: ALL ELIGIBILITY REQUIREMENTS HAVE BEEN MET
We based this action on OHIO ADMINISTRATIVE CODE, Rule 01020

Reason:
JANE DOE IS A RESIDENT OF A PUBLIC INSTITUTION.
We based this action on OHIO ADMINISTRATIVE CODE, Rule 07404

RC: 091 374 MA A 1 A7

KEEP READING >>>

SEQ# 0001029 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000012
DHS 8500 (Rev. 02/98) 9999999999/MA A/01 NOTICE TYPE: AE01A7

AG Name:	Case Number:	Mailing Date:
JANE DOE	9999999999	04/05/1999

This "Important 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.

Ask for a State Hearing if you want to appeal.

Ask for a State Hearing if you disagree with what we are doing or think we are making a mistake. At the state hearing, you can explain your reasons. We will explain our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

We must get your request for a State Hearing by the deadline: 06/09/1999.

Please use the next page ("State Hearing Request") to ask for a State Hearing. Save all the other pages of this notice.

Someone else may help you (a lawyer, social worker, friend, relative, etc.). Someone else may request a hearing for you and come to the hearing with you.

You can also get information about free legal services. For free legal help call the Ohio State Legal Services Association at 1-800-589-5888 (a free call).

AG Name:	Case Number:	Mailing Date:
JANE DOE	9999999999	04/05/1999

STATE HEARING REQUEST

Get this to us by the deadline to ask for a State Hearing!

STEP 1 *Check all the boxes that apply, then sign.*

I want a State Hearing. I am most concerned about (optional):

- ☐ Checks or cash assistance (OWF or DA)
- ☐ Food Stamps
- ☐ Medical assistance (Medicaid, Medicare, LIF, Healthy Start, DA Medical, spenddown, nursing homes, QMB, SLMB, etc.)
- ☐ PRC
- ☐ Other (please explain):_____

(examples: child day care, child support, overpayments, etc.)

☐ I also want a County Conference. (A county conference is a meeting with you and staff from our county department of human services.)

My signature:_____ Date:_____ Phone: (___)_____

STEP 2 *You must complete this part if someone else is helping you with your case (a lawyer, social worker, friend, relative, etc.)*

My authorized representative is:

Name:_____Phone: (___)_____

Address:_____ Fax: (___)_____

_____ E-mail:_____

STEP 3 *Choose one of these ways to send this request to us. We must get this request by the deadline!*

MAIL: Mail only this page. Follow the steps on the back of this page.

FAX: Fax only this side of this page to 614-728-9574 (ODHS Bureau of State Hearings).

E-MAIL: E-mail to "bsh@odhs.state.oh.us". Please include all the information requested in Steps 1 and 2; and all the information from box at the top of this notice (AG Name, Case Number and Mailing Date).

VISIT OR PHONE YOUR CASEWORKER: It is better to ask for a hearing by using mail, fax or e-mail. You may visit or phone your caseworker. Ask for a "State Hearing." Only you may phone. Take all pages of this notice if you visit your caseworker. Mention this notice if you phone.

KEEP READING >>>

Mailing Steps:
(1) Fold this page only along the dotted lines.
(2) Tape or staple after folding.

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO 5249 COLUMBUS OH

POSTAGE WILL BE PAID BY ADDRESSEE

OHIO DEPARTMENT OF HUMAN SERVICES
BUREAU OF STATE HEARINGS
P.O. BOX 182825
COLUMBUS, OHIO 43272-5376

END

PRINT SEQ. 0000012

Client Notice: AE01-A8

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	July, 2000

Description of Notice:	Approval of Food Stamps with no prorated initial benefits
Assistance Categories:	FS
Hearing Rights:	Yes
Program ID:	GAE501
Transaction ID:	Authorization
Frequency:	Daily
Volume (est. monthly):	40,000
Form Number:	DHS 8500

Notes:

WVLH 0023

0000683

IMPORTANT NOTICE

FAIRFIELD COUNTY DEPT OF JOBS AND FAMILY SERVICES
P.O. BOX 890

LANCASTER OH 431300000

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 07/10/2000
From: VICKIE L HESTER
Phone: (614) 653-1701 Ext:

Worker ID: WVLH23
Case Number: 9999999999
AG Name: JANE DOE

Dear JANE DOE

We APPROVED your FOOD STAMPS application of 07/06/2000. You can get $72 for 08/01/2000 through 07/31/2001. You must add each month's food stamps to your Ohio Direction EBT Card by the end of each month.

WARNING! You will lose any food stamps that you fail to add to your Ohio Direction EBT Card by the deadline. After you add food stamps to your Card you may use them whenever you wish.

Contact your county Direction Card EBT office: to get your plastic Card; or to get help with your Card or PIN; or to report your Card lost, stolen or damaged. Call the Helpline (1-800-944-3273) to check your account balance; or to change the location where you add food stamps to your Card.

The people affected by this action are:
JANE D (ELIGIBLE) JOHN D (ELIGIBLE)

Reason: YOU ARE ELIGIBLE UNDER ALL THE RULES
We based this action on OHIO ADMINISTRATIVE CODE, Rule 5101:4-5-07

Reason:
INCREASE IN ASSISTANCE GROUP'S SHELTER COSTS FROM $ 113.00 TO $ 173.00 .
We based this action on OHIO ADMINISTRATIVE CODE, Rule 5101:4-4-23

RC: 091 050 FS 1 A8

KEEP READING >>>

SEQ# 0000022 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000683
DHS 8500 (Rev. 02/98) 9999999999/FS /01 NOTICE TYPE: AE01A8

AG Name:	Case Number:	Mailing Date:
JANE DOE	9999999999	07/10/2000

This "Important 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.

Ask for a State Hearing if you want to appeal.

Ask for a State Hearing if you disagree with what we are doing or think we are making a mistake. At the state hearing, you can explain your reasons. We will explain our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

We must get your request for a State Hearing by the deadline: 10/10/2000.

Please use the next page ("State Hearing Request") to ask for a State Hearing. Save all the other pages of this notice.

Someone else may help you (a lawyer, social worker, friend, relative, etc.). Someone else may request a hearing for you and come to the hearing with you.

You can also get information about free legal services. For free legal help call the Ohio State Legal Services Association at 1-800-589-5888 (a free call).

AG Name:	Case Number:	Mailing Date:
JANE DOE	9999999999	07/10/2000

STATE HEARING REQUEST

Get this to us by the deadline to ask for a State Hearing!

STEP 1 *Check all the boxes that apply, then sign.*

I want a State Hearing. I am most concerned about (optional):

- ☐ Checks or cash assistance (OWF or DA)
- ☐ Food Stamps
- ☐ Medical assistance (Medicaid, Medicare, LIF, Healthy Start, DA Medical, spenddown, nursing homes, QMB, SLMB, etc.)
- ☐ PRC
- ☐ Other (please explain):_____

(examples: child day care, child support, overpayments, etc.)

☐ I also want a County Conference. (A county conference is a meeting with you and staff from our county department of human services.)

My signature:_____ Date:_____ Phone: (___)_____

STEP 2 *You must complete this part if someone else is helping you with your case (a lawyer, social worker, friend, relative, etc.)*

My authorized representative is:

Name:_____Phone: (___)_____

Address:_____ Fax: (___)_____

_____ E-mail:_____

STEP 3 *Choose one of these ways to send this request to us. We must get this request by the deadline!*

MAIL: Mail only this page. Follow the steps on the back of this page.

FAX: Fax only this side of this page to 614-728-9574 (ODHS Bureau of State Hearings).

E-MAIL: E-mail to "bsh@odhs.state.oh.us". Please include all the information requested in Steps 1 and 2; and all the information from box at the top of this notice (AG Name, Case Number and Mailing Date).

VISIT OR PHONE YOUR CASEWORKER: It is better to ask for a hearing by using mail, fax or e-mail. You may visit or phone your caseworker. Ask for a "State Hearing." Only you may phone. Take all pages of this notice if you visit your caseworker. Mention this notice if you phone.

KEEP READING >>>

Mailing Steps:
(1) Fold this page only along the dotted lines.
(2) Tape or staple after folding.

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO 5249 COLUMBUS OH

POSTAGE WILL BE PAID BY ADDRESSEE

OHIO DEPARTMENT OF HUMAN SERVICES
BUREAU OF STATE HEARINGS
P.O. BOX 182825
COLUMBUS, OHIO 43272-5376

END

PRINT SEQ. 0000683

Client Notice AE01-A9

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	July, 2000

Description of Notice:	Approval of expedited Food Stamps
Assistance Categories:	FS
Hearing Rights:	Yes
Program ID:	GAE501
Transaction ID:	Authorization
Frequency:	Daily
Volume (est. monthly):	1,200
Form Number:	DHS 8500

Notes:

WCCK 2912

0000008

IMPORTANT NOTICE

FRANKLIN CO. JO COUNTY DEPT OF HUMAN SERVICES
1055 MT. VERNON AVE

COLUMBUS OH 432030000

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 04/05/1999
From: COMFORT A KENNEH
Phone: (614) 251-4944 Ext:

Worker ID: WCCK25
Case Number: 9999999999
AG Name: JANE DOE

Dear JANE DOE

Your EXPEDITED FOOD STAMP application dated 04/01/1999 has been APPROVED effective 04/01/1999 . You are eligible to receive food stamps benefits from 04/01/1999 through 04/30/1999 in the amount of $497. No more food stamp benefits will be issued until all requested verifications have been received by the county department of human services. If, as a result of the verifications, a change in eligibility or benefit level occurs, the change will be made without further notification to you.

The people affected by this action are:
JANE D (ELIGIBLE) JANE D (ELIGIBLE) JANE D (ELIGIBLE) JOHN D (ELIGIBLE)
JOHN D (ELIGIBLE)

Reason: ASSISTANCE GROUP IS ELIGIBLE FOR EXPEDITED FOOD STAMPS
We based this action on OHIO ADMINISTRATIVE CODE, Rule 5101:4-6-09

Reason: ALL ELIGIBILITY REQUIREMENTS HAVE BEEN MET
We based this action on OHIO ADMINISTRATIVE CODE, Rule 5101:4-5-07

RC: 041 091 FS 1 A9

KEEP READING >>>

SEQ# 0002474 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000008
DHS 8500 (Rev. 02/98) 9999999999/FS /01 NOTICE TYPE: AE01A9

AG Name:	Case Number:	Mailing Date:
JANE DOE	9999999999	04/05/1999

This "Important 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.

Ask for a State Hearing if you want to appeal.

Ask for a State Hearing if you disagree with what we are doing or think we are making a mistake. At the state hearing, you can explain your reasons. We will explain our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

We must get your request for a State Hearing by the deadline: 07/06/1999.

Please use the next page ("State Hearing Request") to ask for a State Hearing. Save all the other pages of this notice.

Someone else may help you (a lawyer, social worker, friend, relative, etc.). Someone else may request a hearing for you and come to the hearing with you.

You can also get information about free legal services. For free legal help call the Ohio State Legal Services Association at 1-800-589-5888 (a free call).

AG Name:	Case Number:	Mailing Date:
JANE DOE	9999999999	04/05/1999

STATE HEARING REQUEST

Get this to us by the deadline to ask for a State Hearing!

STEP 1 *Check all the boxes that apply, then sign.*

I want a State Hearing. I am most concerned about (optional):

- ☐ Checks or cash assistance (OWF or DA)
- ☐ Food Stamps
- ☐ Medical assistance (Medicaid, Medicare, LIF, Healthy Start, DA Medical, spenddown, nursing homes, QMB, SLMB, etc.)
- ☐ PRC
- ☐ Other (please explain):_____

(examples: child day care, child support, overpayments, etc.)

☐ I also want a County Conference. (A county conference is a meeting with you and staff from our county department of human services.)

My signature:_____ Date:_____ Phone: (___)_____

STEP 2 *You must complete this part if someone else is helping you with your case (a lawyer, social worker, friend, relative, etc.)*

My authorized representative is:

Name:_____Phone: (___)_____

Address:_____ Fax: (___)_____

_____ E-mail:_____

STEP 3 *Choose one of these ways to send this request to us. We must get this request by the deadline!*

MAIL: Mail only this page. Follow the steps on the back of this page.

FAX: Fax only this side of this page to 614-728-9574 (ODHS Bureau of State Hearings).

E-MAIL: E-mail to "bsh@odhs.state.oh.us". Please include all the information requested in Steps 1 and 2; and all the information from box at the top of this notice (AG Name, Case Number and Mailing Date).

VISIT OR PHONE YOUR CASEWORKER: It is better to ask for a hearing by using mail, fax or e-mail. You may visit or phone your caseworker. Ask for a "State Hearing." Only you may phone. Take all pages of this notice if you visit your caseworker. Mention this notice if you phone.

KEEP READING >>>

Mailing Steps:
(1) Fold this page only along the dotted lines.
(2) Tape or staple after folding.

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO 5249 COLUMBUS OH

POSTAGE WILL BE PAID BY ADDRESSEE

OHIO DEPARTMENT OF HUMAN SERVICES
BUREAU OF STATE HEARINGS
P.O. BOX 182825
COLUMBUS, OHIO 43272-5376

END

PRINT SEQ. 0000008

Client Notice: AE01-AA

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	July, 2000

Description of Notice:	Approval of Medicaid nursing home vendor payment with retroactive benefits
Assistance Categories:	MA-A, MA-B, MA-D
Hearing Rights:	Yes
Program ID:	GAE501
Transaction ID:	Authorization
Frequency:	Daily
Volume (est. monthly):	1740
Form Number:	DHS 8500
Notes:	

WTLW 1109

0000009

IMPORTANT NOTICE

MARION COUNTY DEPT OF HUMAN SERVICES
363 W. FAIRGROUND ST.
P.O. BOX 1817
MARION OH 433020000

JOHN DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 04/05/1999
From: TERRI L WOLF
Phone: (740) 387-8560 Ext: 0261

Worker ID: WTLW51
Case Number: 9999999999
AG Name: JOHN DOE

Dear JOHN DOE

Your MEDICAID FOR THE AGED application dated 03/09/1999 has been APPROVED effective 03/01/1999. You have been approved for retroactive MEDICAID FOR THE AGED benefits for the month(s) beginning 03/1999, 04/1999. You are responsible for a monthly patient liability of $595 If you have paid for medical services while eligible for Medicaid, you may be able to get your money back. For information call the Medicaid Consumer Hotline at 1-800-324-8680 or TDD 1-800-292-3572.

The people affected by this action are:
JOHN D (ELIGIBLE)

Reason:
JANE DOE 'S PHYSICAL AND\OR MENTAL CONDITION DOES NOT PREVENT DOING PAST RELEVENT WORK.
We based this action on OHIO ADMINISTRATIVE CODE, Rule 07401

Reason: FAILURE TO MEET SPENDDOWN LIABILITY
We based this action on OHIO ADMINISTRATIVE CODE, Rule 07467

Reason: ALL ELIGIBILITY REQUIREMENTS HAVE BEEN MET
We based this action on OHIO ADMINISTRATIVE CODE, Rule 01020

RC: 519 403 091 MA A 1 AA

KEEP READING >>>

SEQ# 0000389 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000009
DHS 8500 (Rev. 02/98) 9999999999/MA A/01 NOTICE TYPE: AE01AA

AG Name:	Case Number:	Mailing Date:
JOHN DOE	9999999999	04/05/1999

This "Important 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.

Ask for a State Hearing if you want to appeal.

Ask for a State Hearing if you disagree with what we are doing or think we are making a mistake. At the state hearing, you can explain your reasons. We will explain our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

We must get your request for a State Hearing by the deadline: 07/06/1999.

Please use the next page ("State Hearing Request") to ask for a State Hearing. Save all the other pages of this notice.

Someone else may help you (a lawyer, social worker, friend, relative, etc.). Someone else may request a hearing for you and come to the hearing with you.

You can also get information about free legal services. For free legal help call the Ohio State Legal Services Association at 1-800-589-5888 (a free call).

AG Name:	Case Number:	Mailing Date:
JOHN DOE	9999999999	04/05/1999

STATE HEARING REQUEST

Get this to us by the deadline to ask for a State Hearing!

STEP 1 *Check all the boxes that apply, then sign.*

I want a State Hearing. I am most concerned about (optional):

- ☐ Checks or cash assistance (OWF or DA)
- ☐ Food Stamps
- ☐ Medical assistance (Medicaid, Medicare, LIF, Healthy Start, DA Medical, spenddown, nursing homes, QMB, SLMB, etc.)
- ☐ PRC
- ☐ Other (please explain):_____

(examples: child day care, child support, overpayments, etc.)

☐ I also want a County Conference. (A county conference is a meeting with you and staff from our county department of human services.)

My signature:_____ Date:_____ Phone: (___)_____

STEP 2 *You must complete this part if someone else is helping you with your case (a lawyer, social worker, friend, relative, etc.)*

My authorized representative is:

Name:_____Phone: (___)_____

Address:_____ Fax: (___)_____

_____ E-mail:_____

STEP 3 *Choose one of these ways to send this request to us. We must get this request by the deadline!*

MAIL: Mail only this page. Follow the steps on the back of this page.

FAX: Fax only this side of this page to 614-728-9574 (ODHS Bureau of State Hearings).

E-MAIL: E-mail to "bsh@odhs.state.oh.us". Please include all the information requested in Steps 1 and 2; and all the information from box at the top of this notice (AG Name, Case Number and Mailing Date).

VISIT OR PHONE YOUR CASEWORKER: It is better to ask for a hearing by using mail, fax or e-mail. You may visit or phone your caseworker. Ask for a "State Hearing." Only you may phone. Take all pages of this notice if you visit your caseworker. Mention this notice if you phone.

KEEP READING >>>

Mailing Steps:
(1) Fold this page only along the dotted lines.
(2) Tape or staple after folding.

JOHN DOE
111 MAIN ST

ANYWHERE OH 99999-9999

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO 5249 COLUMBUS OH

POSTAGE WILL BE PAID BY ADDRESSEE

OHIO DEPARTMENT OF HUMAN SERVICES
BUREAU OF STATE HEARINGS
P.O. BOX 182825
COLUMBUS, OHIO 43272-5376

END

PRINT SEQ. 0000009

Client Notice: AE01-AB

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	July, 2000

Description of Notice:	Approval of QMB Medicaid with no retroactive benefits
Assistance Categories:	MA-L
Hearing Rights:	Yes
Program ID:	GAE501
Transaction ID:	Authorization
Frequency:	Daily
Volume (est. monthly):	2,550
Form Number:	DHS 8500

Notes:

WVLH 0023

0000007

IMPORTANT NOTICE

FAIRFIELD COUNTY DEPT OF HUMAN SERVICES
P.O. BOX 890

LANCASTER OH 431300000

JOHN DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 04/05/1999
From: VICKIE L HESTER
Phone: (614) 653-1701 Ext:

Worker ID: WVLH23
Case Number: 9999999999
AG Name: JOHN DOE

Dear JOHN DOE

Your QUALIFIED MEDICARE BENEFICIARY (QMB) application dated 03/22/1999 has been APPROVED effective 05/01/1999. If you have been approved for Medicaid for the aged, Medicaid for the blind, or Medicaid for the disabled, you will not receive a Qualified Medicare Beneficiary (QMB) health card. If you have been approved for Medicaid for the aged, Medicaid for the blind, or Medicaid for the disabled on a delayed spenddown basis, you will receive a Qualified Medicare Beneficiary (QMB) health card.
If you have paid for medical services while eligible for Medicaid, you may be able to get your money back. For information call the Medicaid Consumer Hotline at 1-800-324-8680 or TDD 1-800-292-3572.

The people affected by this action are:
JOHN D (ELIGIBLE)

Reason: MA-L ELIGIBILITY DOES NOT EXIST IN AN INITIAL MONTH
We based this action on OHIO ADMINISTRATIVE CODE, Rule 07202

Reason: ALL ELIGIBILITY REQUIREMENTS HAVE BEEN MET
We based this action on OHIO ADMINISTRATIVE CODE, Rule 01020

RC: 466 091 MA L 1 AB

KEEP READING >>>

SEQ# 0000071 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000007
DHS 8500 (Rev. 02/98) 9999999999/MA L/01 NOTICE TYPE: AE01AB

AG Name:	Case Number:	Mailing Date:
JOHN DOE	9999999999	04/05/1999

This "Important 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.

Ask for a State Hearing if you want to appeal.

Ask for a State Hearing if you disagree with what we are doing or think we are making a mistake. At the state hearing, you can explain your reasons. We will explain our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

We must get your request for a State Hearing by the deadline: 07/06/1999.

Please use the next page ("State Hearing Request") to ask for a State Hearing. Save all the other pages of this notice.

Someone else may help you (a lawyer, social worker, friend, relative, etc.). Someone else may request a hearing for you and come to the hearing with you.

You can also get information about free legal services. For free legal help call the Ohio State Legal Services Association at 1-800-589-5888 (a free call).

AG Name:	Case Number:	Mailing Date:
JOHN DOE	9999999999	04/05/1999

STATE HEARING REQUEST

Get this to us by the deadline to ask for a State Hearing!

STEP 1 *Check all the boxes that apply, then sign.*

I want a State Hearing. I am most concerned about (optional):

- ☐ Checks or cash assistance (OWF or DA)
- ☐ Food Stamps
- ☐ Medical assistance (Medicaid, Medicare, LIF, Healthy Start, DA Medical, spenddown, nursing homes, QMB, SLMB, etc.)
- ☐ PRC
- ☐ Other (please explain):_____

(examples: child day care, child support, overpayments, etc.)

☐ I also want a County Conference. (A county conference is a meeting with you and staff from our county department of human services.)

My signature:_____ Date:_____ Phone: (___)_____

STEP 2 *You must complete this part if someone else is helping you with your case (a lawyer, social worker, friend, relative, etc.)*

My authorized representative is:

Name:_____Phone: (___)_____

Address:_____ Fax: (___)_____

_____ E-mail:_____

STEP 3 *Choose one of these ways to send this request to us. We must get this request by the deadline!*

MAIL: Mail only this page. Follow the steps on the back of this page.

FAX: Fax only this side of this page to 614-728-9574 (ODHS Bureau of State Hearings).

E-MAIL: E-mail to "bsh@odhs.state.oh.us". Please include all the information requested in Steps 1 and 2; and all the information from box at the top of this notice (AG Name, Case Number and Mailing Date).

VISIT OR PHONE YOUR CASEWORKER: It is better to ask for a hearing by using mail, fax or e-mail. You may visit or phone your caseworker. Ask for a "State Hearing." Only you may phone. Take all pages of this notice if you visit your caseworker. Mention this notice if you phone.

KEEP READING >>>

Mailing Steps:
(1) Fold this page only along the dotted lines.
(2) Tape or staple after folding.

JOHN DOE
111 MAIN ST

ANYWHERE OH 99999-9999

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO 5249 COLUMBUS OH

POSTAGE WILL BE PAID BY ADDRESSEE

OHIO DEPARTMENT OF HUMAN SERVICES
BUREAU OF STATE HEARINGS
P.O. BOX 182825
COLUMBUS, OHIO 43272-5376

END

PRINT SEQ. 0000007

Client Notice: AE01-AC

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	July, 2000

Description of Notice:	Approval of QMB Medicaid with retroactive benefits
Assistance Categories:	MA-L
Hearing Rights:	Yes
Program ID:	GAE501
Transaction ID:	Authorization
Frequency:	Daily
Volume (est. monthly):	1,036
Form Number:	DHS 8500
Notes:	Obsolete - should be AE01-AB

WRAD 1105

0000010

IMPORTANT NOTICE

MARION COUNTY DEPT OF HUMAN SERVICES
363 W. FAIRGROUND ST.
P.O. BOX 1817
MARION OH 433020000

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 04/05/1999
From: RAYMOND A DOUGLAS
Phone: (740) 387-8560 Ext: 0251

Worker ID: WRAD51
Case Number: 9999999999
AG Name: JANE DOE

Dear JANE DOE

Your QUALIFIED MEDICARE BENEFICIARY (QMB) application dated 03/29/1999 has been APPROVED effective 04/01/1999. You have been APPROVED for retroactive QUALIFIED MEDICARE BENEFICIARY (QMB) benefits for the month(s) of 04/1999. If you have been approved for Medicaid for the aged, blind, or disabled, you will not receive a Qualified Medicare Beneficiary (QMB) health card. If you have been approved for Medicaid for the aged, blind, or disabled on a spenddown basis, you will receive a Qualified Medicare Beneficiary (QMB) health card.
If you have paid for medical services while eligible for Medicaid, you may be able to get your money back. For information call the Medicaid Consumer Hotline at 1-800-324-8680 or TDD 1-800-292-3572.

The people affected by this action are:
JANE D (ELIGIBLE)

Reason: ALL ELIGIBILITY REQUIREMENTS HAVE BEEN MET
We based this action on OHIO ADMINISTRATIVE CODE, Rule 01020

RC: 091 MA L 1 AC

KEEP READING >>>

SEQ# 0000392 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000010
DHS 8500 (Rev. 02/98) 9999999999/MA L/01 NOTICE TYPE: AE01AC

AG Name:	Case Number:	Mailing Date:
JANE DOE	9999999999	04/05/1999

This "Important 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.

Ask for a State Hearing if you want to appeal.

Ask for a State Hearing if you disagree with what we are doing or think we are making a mistake. At the state hearing, you can explain your reasons. We will explain our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

We must get your request for a State Hearing by the deadline: 08/25/1999.

Please use the next page ("State Hearing Request") to ask for a State Hearing. Save all the other pages of this notice.

Someone else may help you (a lawyer, social worker, friend, relative, etc.). Someone else may request a hearing for you and come to the hearing with you.

You can also get information about free legal services. For free legal help call the Ohio State Legal Services Association at 1-800-589-5888 (a free call).

AG Name:	Case Number:	Mailing Date:
JANE DOE	9999999999	04/05/1999

STATE HEARING REQUEST

Get this to us by the deadline to ask for a State Hearing!

STEP 1 *Check all the boxes that apply, then sign.*

I want a State Hearing. I am most concerned about (optional):

- ☐ Checks or cash assistance (OWF or DA)
- ☐ Food Stamps
- ☐ Medical assistance (Medicaid, Medicare, LIF, Healthy Start, DA Medical, spenddown, nursing homes, QMB, SLMB, etc.)
- ☐ PRC
- ☐ Other (please explain):_____

(examples: child day care, child support, overpayments, etc.)

☐ I also want a County Conference. (A county conference is a meeting with you and staff from our county department of human services.)

My signature:_____ Date:_____ Phone: (___)_____

STEP 2 *You must complete this part if someone else is helping you with your case (a lawyer, social worker, friend, relative, etc.)*

My authorized representative is:

Name:_____Phone: (___)_____

Address:_____ Fax: (___)_____

_____ E-mail:_____

STEP 3 *Choose one of these ways to send this request to us. We must get this request by the deadline!*

MAIL: Mail only this page. Follow the steps on the back of this page.

FAX: Fax only this side of this page to 614-728-9574 (ODHS Bureau of State Hearings).

E-MAIL: E-mail to "bsh@odhs.state.oh.us". Please include all the information requested in Steps 1 and 2; and all the information from box at the top of this notice (AG Name, Case Number and Mailing Date).

VISIT OR PHONE YOUR CASEWORKER: It is better to ask for a hearing by using mail, fax or e-mail. You may visit or phone your caseworker. Ask for a "State Hearing." Only you may phone. Take all pages of this notice if you visit your caseworker. Mention this notice if you phone.

KEEP READING >>>

Mailing Steps:
(1) Fold this page only along the dotted lines.
(2) Tape or staple after folding.

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO 5249 COLUMBUS OH

POSTAGE WILL BE PAID BY ADDRESSEE

OHIO DEPARTMENT OF HUMAN SERVICES
BUREAU OF STATE HEARINGS
P.O. BOX 182825
COLUMBUS, OHIO 43272-5376

END

PRINT SEQ. 0000010

Client Notice: AE01-AD

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	July, 2000

Description of Notice:	Denial of Medicaid nursing home vendor payment due to an improper resource transfer
Assistance Categories:	MA-A, MA-B, MA-D
Hearing Rights:	Yes
Program ID:	GAE501
Transaction ID:	Authorization
Frequency:	Daily
Volume (est. monthly):	3
Form Number:	DHS 8500
Notes:	Obsolete - should be AE01-AE

WWLP 3727

0000011

IMPORTANT NOTICE

CUYAHOGA COUNTY DEPT OF HUMAN SERVICES
MAIN OFFICE
1641 PAYNE AVE
CLEVELAND OH 441140000

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 05/27/1999
From: WONCINA L PENNYMAN
Phone: (216) 987-7816 Ext:

Worker ID: WWLP18
Case Number: 9999999999
AG Name: JANE DOE

Dear JANE DOE

Your request for NURSING HOME VENDOR PAYMENT dated 01/01/1999 has been DENIED due to an improper transfer of resources. Because of this transfer, you are ineligible for vendor payment from 04/01/1999 to 08/31/2000.

The people affected by this action are:
JANE D (INELIGIBLE)

Reason: NOT ELIGIBLE FOR VENDOR PAYMENT, IMPROPER RESOURCE TRANSFER
We based this action on OHIO ADMINISTRATIVE CODE, Rule 07412

Reason: FAILURE TO MEET SPENDDOWN LIABILITY
We based this action on OHIO ADMINISTRATIVE CODE, Rule 07467

Reason: ALL ELIGIBILITY REQUIREMENTS HAVE BEEN MET
We based this action on OHIO ADMINISTRATIVE CODE, Rule 5101:1-2-10

RC: 475 403 091 MA A 1 AD

KEEP READING >>>

SEQ# 0006974 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000011
DHS 8500 (Rev. 02/98) 9999999999/MA A/01 NOTICE TYPE: AE01AD

AG Name:	Case Number:	Mailing Date:
JANE DOE	9999999999	05/27/1999

This "Important 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.

Ask for a State Hearing if you want to appeal.

Ask for a State Hearing if you disagree with what we are doing or think we are making a mistake. At the state hearing, you can explain your reasons. We will explain our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

We must get your request for a State Hearing by the deadline: 08/25/1999.

Please use the next page ("State Hearing Request") to ask for a State Hearing. Save all the other pages of this notice.

Someone else may help you (a lawyer, social worker, friend, relative, etc.). Someone else may request a hearing for you and come to the hearing with you.

You can also get information about free legal services. For free legal help call the Ohio State Legal Services Association at 1-800-589-5888 (a free call).

AG Name:	Case Number:	Mailing Date:
JANE DOE	9999999999	05/27/1999

STATE HEARING REQUEST

Get this to us by the deadline to ask for a State Hearing!

STEP 1 *Check all the boxes that apply, then sign.*

I want a State Hearing. I am most concerned about (optional):

- ☐ Checks or cash assistance (OWF or DA)
- ☐ Food Stamps
- ☐ Medical assistance (Medicaid, Medicare, LIF, Healthy Start, DA Medical, spenddown, nursing homes, QMB, SLMB, etc.)
- ☐ PRC
- ☐ Other (please explain):_____

(examples: child day care, child support, overpayments, etc.)

☐ I also want a County Conference. (A county conference is a meeting with you and staff from our county department of human services.)

My signature:_____ Date:_____ Phone: (___)_____

STEP 2 *You must complete this part if someone else is helping you with your case (a lawyer, social worker, friend, relative, etc.)*

My authorized representative is:

Name:_____Phone: (___)_____

Address:_____ Fax: (___)_____

_____ E-mail:_____

STEP 3 *Choose one of these ways to send this request to us. We must get this request by the deadline!*

MAIL: Mail only this page. Follow the steps on the back of this page.

FAX: Fax only this side of this page to 614-728-9574 (ODHS Bureau of State Hearings).

E-MAIL: E-mail to "bsh@odhs.state.oh.us". Please include all the information requested in Steps 1 and 2; and all the information from box at the top of this notice (AG Name, Case Number and Mailing Date).

VISIT OR PHONE YOUR CASEWORKER: It is better to ask for a hearing by using mail, fax or e-mail. You may visit or phone your caseworker. Ask for a "State Hearing." Only you may phone. Take all pages of this notice if you visit your caseworker. Mention this notice if you phone.

KEEP READING >>>

Mailing Steps:
(1) Fold this page only along the dotted lines.
(2) Tape or staple after folding.

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO 5249 COLUMBUS OH

POSTAGE WILL BE PAID BY ADDRESSEE

OHIO DEPARTMENT OF HUMAN SERVICES
BUREAU OF STATE HEARINGS
P.O. BOX 182825
COLUMBUS, OHIO 43272-5376

END

PRINT SEQ. 0000011

Client Notice: AE01-AE

A client notice name is composed of th **Notice Type**, which is four characters and a n**Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	July, 2000

Description of Notice:	Notice of a period of ineligibility for Medicaid nursing home vendor payment due to an improper resource transfer
Assistance Categories:	MA-A, MA-B, MA-D
Hearing Rights:	Yes
Program ID:	GAE501
Transaction ID:	Authorization
Frequency:	Daily
Volume (est. monthly):	20
Form Number:	DHS 8500
Notes:	

WDMR 3152

0000007

LUCAS COUNTY DEPT OF HUMAN SERVICES
3210 MONROE ST.
P.O. BOX 10007
TOLEDO OH 436990007

IMPORTANT NOTICE

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 04/05/1999
From: DARLENE RASCZYK
Phone: (419) 213-8359 Ext:

Worker ID: WDMR48
Case Number: 9999999999
AG Name: JANE DOE

Dear JANE DOE

Due to an improper transfer of resources, you will not be eligible for either long term care facility (nursing home) or home and community-based services vendor payment from 10/01/1998 to 04/30/1999.

The people affected by this action are:
JOHN D (ELIGIBLE) JANE D (INELIGIBLE)

Reason: NOT ELIGIBLE FOR VENDOR PAYMENT, IMPROPER RESOURCE TRANSFER
We based this action on OHIO ADMINISTRATIVE CODE, Rule 07412

Reason: FAILURE TO MEET SPENDDOWN LIABILITY
We based this action on OHIO ADMINISTRATIVE CODE, Rule 07467

Reason: ALL ELIGIBILITY REQUIREMENTS HAVE BEEN MET
We based this action on OHIO ADMINISTRATIVE CODE, Rule 01020

RC: 475 403 091 MA A 1 AE

KEEP READING >>>

SEQ# 0006881 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000007
DHS 8500 (Rev. 02/98) 9999999999/MA A/01 NOTICE TYPE: AE01AE

AG Name:	Case Number:	Mailing Date:
JANE DOE	9999999999	04/05/1999

This "Important 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.

Ask for a State Hearing if you want to appeal.

Ask for a State Hearing if you disagree with what we are doing or think we are making a mistake. At the state hearing, you can explain your reasons. We will explain our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

We must get your request for a State Hearing by the deadline: 07/06/1999.

Please use the next page ("State Hearing Request") to ask for a State Hearing. Save all the other pages of this notice.

Someone else may help you (a lawyer, social worker, friend, relative, etc.). Someone else may request a hearing for you and come to the hearing with you.

You can also get information about free legal services. For free legal help call the Ohio State Legal Services Association at 1-800-589-5888 (a free call).

AG Name:	Case Number:	Mailing Date:
JANE DOE	9999999999	04/05/1999

STATE HEARING REQUEST

Get this to us by the deadline to ask for a State Hearing!

STEP 1 *Check all the boxes that apply, then sign.*

I want a State Hearing. I am most concerned about (optional):

- ☐ Checks or cash assistance (OWF or DA)
- ☐ Food Stamps
- ☐ Medical assistance (Medicaid, Medicare, LIF, Healthy Start, DA Medical, spenddown, nursing homes, QMB, SLMB, etc.)
- ☐ PRC
- ☐ Other (please explain):_____

(examples: child day care, child support, overpayments, etc.)

☐ I also want a County Conference. (A county conference is a meeting with you and staff from our county department of human services.)

My signature:_____ Date:_____ Phone: (___)_____

STEP 2 *You must complete this part if someone else is helping you with your case (a lawyer, social worker, friend, relative, etc.)*

My authorized representative is:

Name:_____Phone: (___)_____

Address:_____ Fax: (___)_____

_____ E-mail:_____

STEP 3 *Choose one of these ways to send this request to us. We must get this request by the deadline!*

MAIL: Mail only this page. Follow the steps on the back of this page.

FAX: Fax only this side of this page to 614-728-9574 (ODHS Bureau of State Hearings).

E-MAIL: E-mail to "bsh@odhs.state.oh.us". Please include all the information requested in Steps 1 and 2; and all the information from box at the top of this notice (AG Name, Case Number and Mailing Date).

VISIT OR PHONE YOUR CASEWORKER: It is better to ask for a hearing by using mail, fax or e-mail. You may visit or phone your caseworker. Ask for a "State Hearing." Only you may phone. Take all pages of this notice if you visit your caseworker. Mention this notice if you phone.

KEEP READING >>>

Mailing Steps:
(1) Fold this page only along the dotted lines.
(2) Tape or staple after folding.

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO 5249 COLUMBUS OH

POSTAGE WILL BE PAID BY ADDRESSEE

OHIO DEPARTMENT OF HUMAN SERVICES
BUREAU OF STATE HEARINGS
P.O. BOX 182825
COLUMBUS, OHIO 43272-5376

END

PRINT SEQ. 0000007

Client Notice: AE01-AF

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	July, 2000

Description of Notice:	Termination of Medicaid nursing home vendor payment due to an improper resource transfer
Assistance Categories:	MA-A, MA-B, MA-D
Hearing Rights:	Yes
Program ID:	GAE501
Transaction ID:	Authorization
Frequency:	Daily
Volume (est. monthly):	20
Form Number:	DHS 8500
Notes:	Obsolete - should be AE01AE

IMPORTANT NOTICE

WARREN COUNTY DEPT OF HUMAN SERVICES
416 SOUTH EAST ST.

LEBANON OH 450360000

JOHN DOE
111 MAIN ST.

ANTWHERE, USA 11111-1111

Mailing Date: 06/02/1998
From: JANE DOE
Phone: (301) 777-9311 Ext: 1111

Worker ID: WFAX00
Case Number: 7777777777
AG Name: JOHN DOE

Dear JOHN DOE

Due to an improper transfer of resources, your Medicaid nursing home vendor payment will be terminated effective 06/01/1998. You will not be eligible for either nursing home or home and community-based services vendor payment from 06/01/1998 to 08/01/1998. You will continue to be eligible for all Medicaid services except vendor payment.

The following individuals are members of this assistance group:
DOE J (ELIGIBLE)

REASON: NOT ELIGIBLE FOR VENDOR PAYMENT, IMPROPER RESOURCE TRANSFER
The regulation supporting this action is contained in OHIO PUBLIC ASSISTANCE MANUAL Section 07412

RC: 475 MA A 1 AF

KEEP READING >>>

AG Name:	Case Number:	Mailing Date:
JOHN DOE	7777777777	06/02/1998

This "Important 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.

Ask for a State Hearing if you want to appeal.

Ask for a State Hearing if you disagree with what we are doing or think we are making a mistake. At the state hearing, you can explain your reasons. We will explain our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

We must get your request for a State Hearing by the deadline: 10/10/2000.

Please use the next page ("State Hearing Request") to ask for a State Hearing. Save all the other pages of this notice.

Someone else may help you (a lawyer, social worker, friend, relative, etc.). Someone else may request a hearing for you and come to the hearing with you.

You can also get information about free legal services. For free legal help call the Ohio State Legal Services Association at 1-800-589-5888 (a free call).

AG Name:	Case Number:	Mailing Date:
JOHN DOE	7777777777	06/02/1998

STATE HEARING REQUEST

Get this to us by the deadline to ask for a State Hearing!

STEP 1 *Check all the boxes that apply, then sign.*

I want a State Hearing. I am most concerned about (optional):

- ☐ Checks or cash assistance (OWF or DA)
- ☐ Food Stamps
- ☐ Medical assistance (Medicaid, Medicare, LIF, Healthy Start, DA Medical, spenddown, nursing homes, QMB, SLMB, etc.)
- ☐ PRC
- ☐ Other (please explain):_____

(examples: child day care, child support, overpayments, etc.)

☐ I also want a County Conference. (A county conference is a meeting with you and staff from our county department of human services.)

My signature:_____ Date:_____ Phone: (___)_____

STEP 2 *You must complete this part if someone else is helping you with your case (a lawyer, social worker, friend, relative, etc.)*

My authorized representative is:

Name:_____Phone: (___)_____

Address:_____ Fax: (___)_____

_____ E-mail:_____

STEP 3 *Choose one of these ways to send this request to us. We must get this request by the deadline!*

MAIL: Mail only this page. Follow the steps on the back of this page.

FAX: Fax only this side of this page to 614-728-9574 (ODHS Bureau of State Hearings).

E-MAIL: E-mail to "bsh@odhs.state.oh.us". Please include all the information requested in Steps 1 and 2; and all the information from box at the top of this notice (AG Name, Case Number and Mailing Date).

VISIT OR PHONE YOUR CASEWORKER: It is better to ask for a hearing by using mail, fax or e-mail. You may visit or phone your caseworker. Ask for a "State Hearing." Only you may phone. Take all pages of this notice if you visit your caseworker. Mention this notice if you phone.

KEEP READING >>>

Mailing Steps:
(1) Fold this page only along the dotted lines.
(2) Tape or staple after folding.

JOHN DOE
111 MAIN ST OH 99999-9999

ANYWHERE OH 99999-9999

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO 5249 COLUMBUS OH

POSTAGE WILL BE PAID BY ADDRESSEE

OHIO DEPARTMENT OF HUMAN SERVICES
BUREAU OF STATE HEARINGS
P.O. BOX 182825
COLUMBUS, OHIO 43272-5376

END

PRINT SEQ. 0000668

Client Notice: AE01-AM

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	July, 2000

Description of Notice:	Approval of SLMB Medicaid with no retroactive benefits
Assistance Categories:	MA-US
Hearing Rights:	Yes
Program ID:	GAE501
Transaction ID:	Authorization
Frequency:	Daily
Volume (est. monthly):	167
Form Number:	DHS 8500

Notes:

WPAS 1018

0000009

IMPORTANT NOTICE

PREBLE COUNTY DEPT OF HUMAN SERVICES
P. O. BOX 88
1234 EATON-GETTYSBURG RD.
EATON OH 453200000

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 04/05/1999
From: PAMELA SARVER
Phone: (937) 456-6205 Ext: 0161

Worker ID: WPAS68
Case Number: 9999999999
AG Name: JANE DOE

Dear JANE DOE

Your application for assistance with partial or full payment of your Medicare Part B premium dated 04/02/1999 has been approved effective 05/01/1999. Medicaid will not pay for any of your Medicare cost-sharing expenses such as co-insurance or deductibles. If you have also been approved for Medicaid for the aged, blind or disabled you will receive a Medicaid health card. If you have not been approved for Medicaid for the aged, blind or disabled you will not receive a Medicaid health card.
If you have paid for medical services while eligible for Medicaid, you may be able to get your money back. For information call the Medicaid Consumer Hotline at 1-800-324-8680 or TDD 1-800-292-3572.

The people affected by this action are:
JANE D (ELIGIBLE)

Reason: ALL ELIGIBILITY REQUIREMENTS HAVE BEEN MET
We based this action on OHIO ADMINISTRATIVE CODE, Rule 01020

RC: 091 MAUS 1 AM

KEEP READING >>>

SEQ# 0001376 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000009
DHS 8500 (Rev. 02/98) 9999999999/MAUS/01 NOTICE TYPE: AE01AM

AG Name:	Case Number:	Mailing Date:
JANE DOE	9999999999	04/05/1999

This "Important 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.

Ask for a State Hearing if you want to appeal.

Ask for a State Hearing if you disagree with what we are doing or think we are making a mistake. At the state hearing, you can explain your reasons. We will explain our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

We must get your request for a State Hearing by the deadline: 07/06/1999.

Please use the next page ("State Hearing Request") to ask for a State Hearing. Save all the other pages of this notice.

Someone else may help you (a lawyer, social worker, friend, relative, etc.). Someone else may request a hearing for you and come to the hearing with you.

You can also get information about free legal services. For free legal help call the Ohio State Legal Services Association at 1-800-589-5888 (a free call).

AG Name:	Case Number:	Mailing Date:
JANE DOE	9999999999	04/05/1999

STATE HEARING REQUEST

Get this to us by the deadline to ask for a State Hearing!

STEP 1 *Check all the boxes that apply, then sign.*

I want a State Hearing. I am most concerned about (optional):

- ☐ Checks or cash assistance (OWF or DA)
- ☐ Food Stamps
- ☐ Medical assistance (Medicaid, Medicare, LIF, Healthy Start, DA Medical, spenddown, nursing homes, QMB, SLMB, etc.)
- ☐ PRC
- ☐ Other (please explain):_____

(examples: child day care, child support, overpayments, etc.)

☐ I also want a County Conference. (A county conference is a meeting with you and staff from our county department of human services.)

My signature:_____ Date:_____ Phone: (___)_____

STEP 2 *You must complete this part if someone else is helping you with your case (a lawyer, social worker, friend, relative, etc.)*

My authorized representative is:

Name:_____Phone: (___)_____

Address:_____ Fax: (___)_____

_____ E-mail:_____

STEP 3 *Choose one of these ways to send this request to us. We must get this request by the deadline!*

MAIL: Mail only this page. Follow the steps on the back of this page.

FAX: Fax only this side of this page to 614-728-9574 (ODHS Bureau of State Hearings).

E-MAIL: E-mail to "bsh@odhs.state.oh.us". Please include all the information requested in Steps 1 and 2; and all the information from box at the top of this notice (AG Name, Case Number and Mailing Date).

VISIT OR PHONE YOUR CASEWORKER: It is better to ask for a hearing by using mail, fax or e-mail. You may visit or phone your caseworker. Ask for a "State Hearing." Only you may phone. Take all pages of this notice if you visit your caseworker. Mention this notice if you phone.

KEEP READING >>>

Mailing Steps:
(1) Fold this page only along the dotted lines.
(2) Tape or staple after folding.

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO 5249 COLUMBUS OH

POSTAGE WILL BE PAID BY ADDRESSEE

OHIO DEPARTMENT OF HUMAN SERVICES
BUREAU OF STATE HEARINGS
P.O. BOX 182825
COLUMBUS, OHIO 43272-5376

END

PRINT SEQ. 0000009

Client Notice: AE01-AN

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	July, 2000

Description of Notice:	Approval of SLMB Medicaid with retroactive benefits
Assistance Categories:	MA-US
Hearing Rights:	Yes
Program ID:	GAE501
Transaction ID:	Authorization
Frequency:	Daily
Volume (est. monthly):	1,670
Form Number:	DHS 8500

Notes:

WVLH 0023

0000004

IMPORTANT NOTICE

FAIRFIELD COUNTY DEPT OF HUMAN SERVICES
P.O. BOX 890

LANCASTER OH 431300000

JOHN DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 04/05/1999
From: VICKIE L HESTER
Phone: (614) 653-1701 Ext:

Worker ID: WVLH23
Case Number: 9999999999
AG Name: JOHN DOE

Dear JOHN DOE

Your SPECIFIED LOW-INCOME MEDICARE BENEFICIARY (SLMB) application dated 03/17/1999 has been APPROVED effective 03/01/1999. Under the SLMB program, your Medicare Part B premium will be paid by Medicaid. Medicaid will not pay for any of your Medicare cost-sharing expenses such as co-insurance or deductibles. If you have also been approved for Medicaid for the aged, blind or disabled you will receive a Medicaid health card. If you have not been approved for Medicaid for the aged, blind or disabled you will not receive a Medicaid health card. You have also been approved for retroactive SLMB benefits for the following month(s): 03/1999, 04/1999.
If you have paid for medical services while eligible for Medicaid, you may be able to get your money back. For information call the Medicaid Consumer Hotline at 1-800-324-8680 or TDD 1-800-292-3572.

The people affected by this action are:
JOHN D (ELIGIBLE) JANE D (ELIGIBLE)

Reason:
YOU ARE ELIGIBLE TO HAVE THE HOME HEALTH CARE PORTION OF YOUR MEDICARE PART B PREMIUM PAID BY THE STATE. YOU WILL NOT RECEIVE A MEDICAID HEALTH CARD WITH THIS BENEFIT.
We based this action on OHIO ADMINISTRATIVE CODE, Rule 07213

Reason: YOUR INCOME EXCEEDS 135% OF POVERTY LEVEL FOR ELIGIBILITY
We based this action on OHIO ADMINISTRATIVE CODE, Rule 07213

Reason: ALL ELIGIBILITY REQUIREMENTS HAVE BEEN MET
We based this action on OHIO ADMINISTRATIVE CODE, Rule 01020

RC: 132 618 091 MAUS 1 AN

KEEP READING >>>

SEQ# 0000061 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000004
DHS 8500 (Rev. 02/98) 9999999999/MAUS/01 NOTICE TYPE: AE01AN

AG Name:	Case Number:	Mailing Date:
JOHN DOE	9999999999	04/05/1999

This "Important 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.

Ask for a State Hearing if you want to appeal.

Ask for a State Hearing if you disagree with what we are doing or think we are making a mistake. At the state hearing, you can explain your reasons. We will explain our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

We must get your request for a State Hearing by the deadline: 07/06/1999.

Please use the next page ("State Hearing Request") to ask for a State Hearing. Save all the other pages of this notice.

Someone else may help you (a lawyer, social worker, friend, relative, etc.). Someone else may request a hearing for you and come to the hearing with you.

You can also get information about free legal services. For free legal help call the Ohio State Legal Services Association at 1-800-589-5888 (a free call).

AG Name:	Case Number:	Mailing Date:
JOHN DOE	9999999999	04/05/1999

STATE HEARING REQUEST

Get this to us by the deadline to ask for a State Hearing!

STEP 1 *Check all the boxes that apply, then sign.*

I want a State Hearing. I am most concerned about (optional):

- ☐ Checks or cash assistance (OWF or DA)
- ☐ Food Stamps
- ☐ Medical assistance (Medicaid, Medicare, LIF, Healthy Start, DA Medical, spenddown, nursing homes, QMB, SLMB, etc.)
- ☐ PRC
- ☐ Other (please explain):_____

(examples: child day care, child support, overpayments, etc.)

☐ I also want a County Conference. (A county conference is a meeting with you and staff from our county department of human services.)

My signature:_____ Date:_____ Phone: (___)_____

STEP 2 *You must complete this part if someone else is helping you with your case (a lawyer, social worker, friend, relative, etc.)*

My authorized representative is:

Name:_____Phone: (___)_____

Address:_____ Fax: (___)_____

_____ E-mail:_____

STEP 3 *Choose one of these ways to send this request to us. We must get this request by the deadline!*

MAIL: Mail only this page. Follow the steps on the back of this page.

FAX: Fax only this side of this page to 614-728-9574 (ODHS Bureau of State Hearings).

E-MAIL: E-mail to "bsh@odhs.state.oh.us". Please include all the information requested in Steps 1 and 2; and all the information from box at the top of this notice (AG Name, Case Number and Mailing Date).

VISIT OR PHONE YOUR CASEWORKER: It is better to ask for a hearing by using mail, fax or e-mail. You may visit or phone your caseworker. Ask for a "State Hearing." Only you may phone. Take all pages of this notice if you visit your caseworker. Mention this notice if you phone.

KEEP READING >>>

Mailing Steps:
(1) Fold this page only along the dotted lines.
(2) Tape or staple after folding.

JOHN DOE
111 MAIN ST

ANYWHERE OH 99999-9999

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO 5249 COLUMBUS OH

POSTAGE WILL BE PAID BY ADDRESSEE

OHIO DEPARTMENT OF HUMAN SERVICES
BUREAU OF STATE HEARINGS
P.O. BOX 182825
COLUMBUS, OHIO 43272-5376

END

PRINT SEQ. 0000004

Client Notice: AE01-C1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	July, 2000

Description of Notice:	Notice of continued benefits with no change
Assistance Categories:	All
Hearing Rights:	Yes
Program ID:	GAE501
Transaction ID:	Authorization
Frequency:	Daily
Volume (est. monthly):	123,770
Form Number:	DHS 8500

Notes:

WDAB 0022

0000001

IMPORTANT NOTICE

FAIRFIELD COUNTY DEPT OF HUMAN SERVICES
P.O. BOX 890

LANCASTER OH 431300000

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 04/05/1999
From: DEBORAH K BASH
Phone: (614) 653-1701 Ext: 6718

Worker ID: WDAB23
Case Number: 9999999999
AG Name: JANE DOE

Dear JANE DOE

Your MEDICAID FOR THE AGED benefits will CONTINUE with no change.
If you have paid for medical services while eligible for Medicaid, you may be able to get your money back. For information call the Medicaid Consumer Hotline at 1-800-324-8680 or TDD 1-800-292-3572.

The people affected by this action are:
JANE D (INELIGIBLE)

Reason: FAILURE TO MEET SPENDDOWN LIABILITY
We based this action on OHIO ADMINISTRATIVE CODE, Rule 07467

Reason: MEDICAID ELIGIBILITY APPROVED ON A DELAYED SPEND-DOWN BASIS
We based this action on OHIO ADMINISTRATIVE CODE, Rule 07467

RC: 403 040 MA A 1 C1

KEEP READING >>>

SEQ# 0000003 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000001
DHS 8500 (Rev. 02/98) 9999999999/MA A/01 NOTICE TYPE: AE01C1

AG Name:	Case Number:	Mailing Date:
JANE DOE	9999999999	04/05/1999

This "Important 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.

Ask for a State Hearing if you want to appeal.

Ask for a State Hearing if you disagree with what we are doing or think we are making a mistake. At the state hearing, you can explain your reasons. We will explain our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

We must get your request for a State Hearing by the deadline: 06/09/1999.

Please use the next page ("State Hearing Request") to ask for a State Hearing. Save all the other pages of this notice.

Someone else may help you (a lawyer, social worker, friend, relative, etc.). Someone else may request a hearing for you and come to the hearing with you.

You can also get information about free legal services. For free legal help call the Ohio State Legal Services Association at 1-800-589-5888 (a free call).

AG Name:	Case Number:	Mailing Date:
JANE DOE	9999999999	04/05/1999

STATE HEARING REQUEST

Get this to us by the deadline to ask for a State Hearing!

STEP 1 *Check all the boxes that apply, then sign.*

I want a State Hearing. I am most concerned about (optional):

- ☐ Checks or cash assistance (OWF or DA)
- ☐ Food Stamps
- ☐ Medical assistance (Medicaid, Medicare, LIF, Healthy Start, DA Medical, spenddown, nursing homes, QMB, SLMB, etc.)
- ☐ PRC
- ☐ Other (please explain):_____

(examples: child day care, child support, overpayments, etc.)

☐ I also want a County Conference. (A county conference is a meeting with you and staff from our county department of human services.)

My signature:_____ Date:_____ Phone: (___)_____

STEP 2 *You must complete this part if someone else is helping you with your case (a lawyer, social worker, friend, relative, etc.)*

My authorized representative is:

Name:_____Phone: (___)_____

Address:_____ Fax: (___)_____

_____ E-mail:_____

STEP 3 *Choose one of these ways to send this request to us. We must get this request by the deadline!*

MAIL: Mail only this page. Follow the steps on the back of this page.

FAX: Fax only this side of this page to 614-728-9574 (ODHS Bureau of State Hearings).

E-MAIL: E-mail to "bsh@odhs.state.oh.us". Please include all the information requested in Steps 1 and 2; and all the information from box at the top of this notice (AG Name, Case Number and Mailing Date).

VISIT OR PHONE YOUR CASEWORKER: It is better to ask for a hearing by using mail, fax or e-mail. You may visit or phone your caseworker. Ask for a "State Hearing." Only you may phone. Take all pages of this notice if you visit your caseworker. Mention this notice if you phone.

KEEP READING >>>

Mailing Steps:
(1) Fold this page only along the dotted lines.
(2) Tape or staple after folding.

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO 5249 COLUMBUS OH

POSTAGE WILL BE PAID BY ADDRESSEE

OHIO DEPARTMENT OF HUMAN SERVICES
BUREAU OF STATE HEARINGS
P.O. BOX 182825
COLUMBUS, OHIO 43272-5376

END

PRINT SEQ. 0000001

Client Notice: AE01-D1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	July, 2000

Description of Notice:	Denial of benefits
Assistance Categories:	All except GA-A, -U, MA-Z, -G
Hearing Rights:	Yes
Program ID:	GAE501
Transaction ID:	Authorization
Frequency:	Daily
Volume (est. monthly):	219,120
Form Number:	DHS 8500
Notes:	GA-A and GA-U have been dropped from the assistance group 7/31/1995.

WDGJ 0021

0000002

IMPORTANT NOTICE

FAIRFIELD COUNTY DEPT OF HUMAN SERVICES
P.O. BOX 890

LANCASTER OH 431300000

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 03/11/1999
From: DENNIS G JOHNSON
Phone: (614) 653-1701 Ext:

Worker ID: WDGJ23
Case Number: 9999999999
AG Name: JANE DOE

Dear JANE DOE

We DENIED your QUALIFIED MEDICARE BENEFICIARY (QMB) application of 10/01/1998.

The people affected by this action are:
JANE D (INELIGIBLE)

Reason: INCOME REPORTED EXCEEDS THE PROGRAM ELIGIBILITY STANDARDS
We based this action on OHIO ADMINISTRATIVE CODE, Rule 07431

RC: 375 MA L 1 D1

KEEP READING >>>

SEQ# 0000005 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000002
DHS 8500 (Rev. 02/98) 9999999999/MA L/01 NOTICE TYPE: AE01D1

AG Name:	Case Number:	Mailing Date:
JANE DOE	9999999999	03/11/1999

This "Important 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.

Ask for a State Hearing if you want to appeal.

Ask for a State Hearing if you disagree with what we are doing or think we are making a mistake. At the state hearing, you can explain your reasons. We will explain our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

We must get your request for a State Hearing by the deadline: 07/06/1999.

Please use the next page ("State Hearing Request") to ask for a State Hearing. Save all the other pages of this notice.

Someone else may help you (a lawyer, social worker, friend, relative, etc.). Someone else may request a hearing for you and come to the hearing with you.

You can also get information about free legal services. For free legal help call the Ohio State Legal Services Association at 1-800-589-5888 (a free call).

AG Name:	Case Number:	Mailing Date:
JANE DOE	9999999999	03/11/1999

STATE HEARING REQUEST

Get this to us by the deadline to ask for a State Hearing!

STEP 1 *Check all the boxes that apply, then sign.*

I want a State Hearing. I am most concerned about (optional):

- ☐ Checks or cash assistance (OWF or DA)
- ☐ Food Stamps
- ☐ Medical assistance (Medicaid, Medicare, LIF, Healthy Start, DA Medical, spenddown, nursing homes, QMB, SLMB, etc.)
- ☐ PRC
- ☐ Other (please explain):_____

(examples: child day care, child support, overpayments, etc.)

☐ I also want a County Conference. (A county conference is a meeting with you and staff from our county department of human services.)

My signature:_____ Date:_____ Phone: (___)_____

STEP 2 *You must complete this part if someone else is helping you with your case (a lawyer, social worker, friend, relative, etc.)*

My authorized representative is:

Name:_____Phone: (___)_____

Address:_____ Fax: (___)_____

_____ E-mail:_____

STEP 3 *Choose one of these ways to send this request to us. We must get this request by the deadline!*

MAIL: Mail only this page. Follow the steps on the back of this page.

FAX: Fax only this side of this page to 614-728-9574 (ODHS Bureau of State Hearings).

E-MAIL: E-mail to "bsh@odhs.state.oh.us". Please include all the information requested in Steps 1 and 2; and all the information from box at the top of this notice (AG Name, Case Number and Mailing Date).

VISIT OR PHONE YOUR CASEWORKER: It is better to ask for a hearing by using mail, fax or e-mail. You may visit or phone your caseworker. Ask for a "State Hearing." Only you may phone. Take all pages of this notice if you visit your caseworker. Mention this notice if you phone.

KEEP READING >>>

Mailing Steps:
(1) Fold this page only along the dotted lines.
(2) Tape or staple after folding.

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO 5249 COLUMBUS OH

POSTAGE WILL BE PAID BY ADDRESSEE

OHIO DEPARTMENT OF HUMAN SERVICES
BUREAU OF STATE HEARINGS
P.O. BOX 182825
COLUMBUS, OHIO 43272-5376

END

PRINT SEQ. 0000002

Client Notice: AE01-D2

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	July, 2000

Description of Notice:	Denial of SLMB Medicaid
Assistance Categories:	MA-US
Hearing Rights:	Yes
Program ID:	GAE501
Transaction ID:	Authorization
Frequency:	Daily
Volume (est. monthly):	9000
Form Number:	DHS 8500

Notes:

0000054 WVAW 0025

FAIRFIELD COUNTY DEPT OF HUMAN SERVICES
P.O. BOX 890

LANCASTER OH 431300000

IMPORTANT NOTICE

JANE DOE
111 MAIN ST.

ANYWHERE, USA 11111-1111

Mailing Date: 05/13/1998
From: VICTORIA A WINKELMAN
Phone: (614) 653-1701 Ext:

Worker ID: WVAW23
Case Number: 1111111111
AG Name: JANE DOE

Dear JANE DOE

Your SPECIFIED LOW-INCOME MEDICARE BENEFICIARY (SLMB) application dated 05/12/1998 has been DENIED effective 05/12/1998. SLMB pays for Medicare Part B premiums only.

The people affected by this action are:
JANE D (INELIGIBLE)

Reason: YOUR INCOME IS LESS THAN THE QMB STANDARD
YOU WOULD BE ELIGIBLE AS A QUALIFIED MEDICARE BENEFICIARY INDIVIDUAL BECAUSE YOUR INCOME IS LESS THAN 100% OF POVERTY.
We based this action on OHIO PUBLIC ASSISTANCE MANUAL Section 07212

RC: 621 MAUS 1 D2

KEEP READING >>>

SEQ# 0000015 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000054
DHS 8500 (Rev. 02/98) 1111111111/MAUS/01 NOTICE TYPE: AE01D2

AG Name:	Case Number:	Mailing Date:
JANE DOE	1111111111	05/13/1998

This "Important 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.

Ask for a State Hearing if you want to appeal.

Ask for a State Hearing if you disagree with what we are doing or think we are making a mistake. At the state hearing, you can explain your reasons. We will explain our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

We must get your request for a State Hearing by the deadline: 10/10/2000.

Please use the next page ("State Hearing Request") to ask for a State Hearing. Save all the other pages of this notice.

Someone else may help you (a lawyer, social worker, friend, relative, etc.). Someone else may request a hearing for you and come to the hearing with you.

You can also get information about free legal services. For free legal help call the Ohio State Legal Services Association at 1-800-589-5888 (a free call).

AG Name:	Case Number:	Mailing Date:
JANE DOE	1111111111	05/13/1998

STATE HEARING REQUEST

Get this to us by the deadline to ask for a State Hearing!

STEP 1 *Check all the boxes that apply, then sign.*

I want a State Hearing. I am most concerned about (optional):

- ☐ Checks or cash assistance (OWF or DA)
- ☐ Food Stamps
- ☐ Medical assistance (Medicaid, Medicare, LIF, Healthy Start, DA Medical, spenddown, nursing homes, QMB, SLMB, etc.)
- ☐ PRC
- ☐ Other (please explain):_____

(examples: child day care, child support, overpayments, etc.)

☐ I also want a County Conference. (A county conference is a meeting with you and staff from our county department of human services.)

My signature:_____ Date:_____ Phone: (___)_____

STEP 2 *You must complete this part if someone else is helping you with your case (a lawyer, social worker, friend, relative, etc.)*

My authorized representative is:

Name:_____Phone: (___)_____

Address:_____ Fax: (___)_____

_____ E-mail:_____

STEP 3 *Choose one of these ways to send this request to us. We must get this request by the deadline!*

MAIL: Mail only this page. Follow the steps on the back of this page.

FAX: Fax only this side of this page to 614-728-9574 (ODHS Bureau of State Hearings).

E-MAIL: E-mail to "bsh@odhs.state.oh.us". Please include all the information requested in Steps 1 and 2; and all the information from box at the top of this notice (AG Name, Case Number and Mailing Date).

VISIT OR PHONE YOUR CASEWORKER: It is better to ask for a hearing by using mail, fax or e-mail. You may visit or phone your caseworker. Ask for a "State Hearing." Only you may phone. Take all pages of this notice if you visit your caseworker. Mention this notice if you phone.

KEEP READING >>>

Mailing Steps:
(1) Fold this page only along the dotted lines.
(2) Tape or staple after folding.

JANE DOE
111 MAIN ST OH 99999-9999

ANYWHERE OH 99999-9999

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO 5249 COLUMBUS OH

POSTAGE WILL BE PAID BY ADDRESSEE

OHIO DEPARTMENT OF HUMAN SERVICES
BUREAU OF STATE HEARINGS
P.O. BOX 182825
COLUMBUS, OHIO 43272-5376

END

PRINT SEQ. 0000668

Client Notice: AE01-H1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	July, 2000

Description of Notice:	Notice of held benefit
Assistance Categories:	ADC, GA, MA
Hearing Rights:	Yes
Program ID:	GSF001
Transaction ID:	Authorization
Frequency:	Daily
Volume (est. monthly):	200
Form Number:	DHS 8500
Notes:	The General Assistance program was discontinued as of 7/31/95

WRAJ 1105

0000010

IMPORTANT NOTICE

CLARK COUNTY DEPT OF HUMAN SERVICES
1345 LAGONDA AVE

SPRINGFIELD OH 455030000

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 05/21/1999
From: RUTH A JENKINS
Phone: (937) 327-1925 Ext:

Worker ID: WRAJ12
Case Number: 9999999999
AG Name: JANE DOE

Dear JANE DOE

Your OHIO WORKS FIRST (OWF) benefit for the month of 06/99 will be HELD and not mailed.

The people affected by this action are:
JANE D (INELIGIBLE) JANE D (INELIGIBLE) JANE D (INELIGIBLE) JANE D (INELIGIBLE) JANE D (INELIGIBLE)

Reason: BENEFIT RETURNED NO DISPOSITION
We based this action on OHIO ADMINISTRATIVE CODE, Rule 5101:1-2-55

RC: 551 ADCR 2 H1

KEEP READING >>>

SEQ# 0001446 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000010
DHS 8500 (Rev. 02/98) 9999999999/ADCR/02 NOTICE TYPE: AE01H1

This "Important 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.

Ask for a State Hearing if you want to appeal.

Ask for a State Hearing if you disagree with what we are doing or think we are making a mistake. At the state hearing, you can explain your reasons. We will explain our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

We must get your request for a State Hearing by the deadline: 06/09/1999.

Please use the next page ("State Hearing Request") to ask for a State Hearing. Save all the other pages of this notice.

Someone else may help you (a lawyer, social worker, friend, relative, etc.). Someone else may request a hearing for you and come to the hearing with you.

You can also get information about free legal services. For free legal help call the Ohio State Legal Services Association at 1-800-589-5888 (a free call).

AG Name:	Case Number:	Mailing Date:
JANE DOE	9999999999	05/21/1999

STATE HEARING REQUEST

Get this to us by the deadline to ask for a State Hearing!

STEP 1 *Check all the boxes that apply, then sign.*

I want a State Hearing. I am most concerned about (optional):

- ☐ Checks or cash assistance (OWF or DA)
- ☐ Food Stamps
- ☐ Medical assistance (Medicaid, Medicare, LIF, Healthy Start, DA Medical, spenddown, nursing homes, QMB, SLMB, etc.)
- ☐ PRC
- ☐ Other (please explain):_____

(examples: child day care, child support, overpayments, etc.)

☐ I also want a County Conference. (A county conference is a meeting with you and staff from our county department of human services.)

My signature:_____ Date:_____ Phone: (___)_____

STEP 2 *You must complete this part if someone else is helping you with your case (a lawyer, social worker, friend, relative, etc.)*

My authorized representative is:

Name:_____Phone: (___)_____

Address:_____ Fax: (___)_____

_____ E-mail:_____

STEP 3 *Choose one of these ways to send this request to us. We must get this request by the deadline!*

MAIL: Mail only this page. Follow the steps on the back of this page.

FAX: Fax only this side of this page to 614-728-9574 (ODHS Bureau of State Hearings).

E-MAIL: E-mail to "bsh@odhs.state.oh.us". Please include all the information requested in Steps 1 and 2; and all the information from box at the top of this notice (AG Name, Case Number and Mailing Date).

VISIT OR PHONE YOUR CASEWORKER: It is better to ask for a hearing by using mail, fax or e-mail. You may visit or phone your caseworker. Ask for a "State Hearing." Only you may phone. Take all pages of this notice if you visit your caseworker. Mention this notice if you phone.

KEEP READING >>>

Mailing Steps:
(1) Fold this page only along the dotted lines.
(2) Tape or staple after folding.

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO 5249 COLUMBUS OH

POSTAGE WILL BE PAID BY ADDRESSEE

OHIO DEPARTMENT OF HUMAN SERVICES
BUREAU OF STATE HEARINGS
P.O. BOX 182825
COLUMBUS, OHIO 43272-5376

END

PRINT SEQ. 0000010

Client Notice: AE01-I1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	July, 2000

Description of Notice:	Increase in benefits
Assistance Categories:	ADC, GA, FS, MA (OSS)
Hearing Rights:	Yes
Program ID:	GAE501
Transaction ID:	Authorization
Frequency:	Daily
Volume (est. monthly):	39012
Form Number:	DHS 8500
Notes:	The General Assistance program was discontinued as of 7/31/95

WMAM 0062

0000003

IMPORTANT NOTICE

FAIRFIELD COUNTY DEPT OF HUMAN SERVICES
P.O. BOX 890

LANCASTER OH 431300000

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 03/11/1999
From: MARGARET A MOHLER
Phone: (614) 653-1701 Ext: 6808

Worker ID: WMAM23
Case Number: 9999999999
AG Name: JANE DOE

Dear JANE DOE

We will RAISE your FOOD STAMP from $0 to $434 each month starting 04/01/1999.

The people affected by this action are:
JOHN D (ELIGIBLE) JANE D (ELIGIBLE) JOHN D (ELIGIBLE) JANE D (ELIGIBLE)
JANE D (ELIGIBLE) JANE D (ELIGIBLE)

Reason: ALL ELIGIBILITY REQUIREMENTS HAVE BEEN MET
We based this action on OHIO ADMINISTRATIVE CODE, Rule 5101:4-5-07

RC: 091 FS 1 I1

KEEP READING >>>

SEQ# 0000035 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000003
DHS 8500 (Rev. 02/98) 9999999999/FS /01 NOTICE TYPE: AE01I1

AG Name:	Case Number:	Mailing Date:
JANE DOE	9999999999	03/11/1999

This "Important 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.

Ask for a State Hearing if you want to appeal.

Ask for a State Hearing if you disagree with what we are doing or think we are making a mistake. At the state hearing, you can explain your reasons. We will explain our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

We must get your request for a State Hearing by the deadline: 06/09/1999.

Please use the next page ("State Hearing Request") to ask for a State Hearing. Save all the other pages of this notice.

Someone else may help you (a lawyer, social worker, friend, relative, etc.). Someone else may request a hearing for you and come to the hearing with you.

You can also get information about free legal services. For free legal help call the Ohio State Legal Services Association at 1-800-589-5888 (a free call).

AG Name:	Case Number:	Mailing Date:
JANE DOE	9999999999	03/11/1999

STATE HEARING REQUEST

Get this to us by the deadline to ask for a State Hearing!

STEP 1 *Check all the boxes that apply, then sign.*

I want a State Hearing. I am most concerned about (optional):

- ☐ Checks or cash assistance (OWF or DA)
- ☐ Food Stamps
- ☐ Medical assistance (Medicaid, Medicare, LIF, Healthy Start, DA Medical, spenddown, nursing homes, QMB, SLMB, etc.)
- ☐ PRC
- ☐ Other (please explain):_____

(examples: child day care, child support, overpayments, etc.)

☐ I also want a County Conference. (A county conference is a meeting with you and staff from our county department of human services.)

My signature:_____ Date:_____ Phone: (___)_____

STEP 2 *You must complete this part if someone else is helping you with your case (a lawyer, social worker, friend, relative, etc.)*

My authorized representative is:

Name:_____Phone: (___)_____

Address:_____ Fax: (___)_____

_____ E-mail:_____

STEP 3 *Choose one of these ways to send this request to us. We must get this request by the deadline!*

MAIL: Mail only this page. Follow the steps on the back of this page.

FAX: Fax only this side of this page to 614-728-9574 (ODHS Bureau of State Hearings).

E-MAIL: E-mail to "bsh@odhs.state.oh.us". Please include all the information requested in Steps 1 and 2; and all the information from box at the top of this notice (AG Name, Case Number and Mailing Date).

VISIT OR PHONE YOUR CASEWORKER: It is better to ask for a hearing by using mail, fax or e-mail. You may visit or phone your caseworker. Ask for a "State Hearing." Only you may phone. Take all pages of this notice if you visit your caseworker. Mention this notice if you phone.

KEEP READING >>>

Mailing Steps:
(1) Fold this page only along the dotted lines.
(2) Tape or staple after folding.

JANE DOE
111 MIAN ST

ANYWHERE OH 99999-9999

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO 5249 COLUMBUS OH

POSTAGE WILL BE PAID BY ADDRESSEE

OHIO DEPARTMENT OF HUMAN SERVICES
BUREAU OF STATE HEARINGS
P.O. BOX 182825
COLUMBUS, OHIO 43272-5376

END

PRINT SEQ. 0000003

Client Notice: AE01-I2

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	July, 2000

Description of Notice:	Decrease in Medicaid spenddown liability
Assistance Categories:	MA (A, B, D, L, J)
Hearing Rights:	Yes
Program ID:	GAE501
Transaction ID:	Authorization
Frequency:	Daily
Volume (est. monthly):	2300
Form Number:	DHS 8500

Notes:

WDMT 1227

0000008

IMPORTANT NOTICE

LUCAS COUNTY DEPT OF HUMAN SERVICES
3210 MONROE ST.
P.O. BOX 10007
TOLEDO OH 436990007

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 03/11/1999
From: D. TURNER
Phone: (419) 213-8225 Ext:

Worker ID: WDMT48
Case Number: 9999999999
AG Name: JANE DOE

Dear JANE DOE

We will LOWER your MEDICAID FOR THE AGED spenddown from $661 to $655 each month starting 04/01/1999.
If you have paid for medical services while eligible for Medicaid, you may be able to get your money back. For information call the Medicaid Consumer Hotline at 1-800-324-8680 or TDD 1-800-292-3572.

The people affected by this action are:
JANE D (INELIGIBLE)

Reason: FAILURE TO MEET SPENDDOWN LIABILITY
We based this action on OHIO ADMINISTRATIVE CODE, Rule 07467

Reason: MEDICAID ELIGIBILITY APPROVED ON A DELAYED SPEND-DOWN BASIS
We based this action on OHIO ADMINISTRATIVE CODE, Rule 07467

RC: 403 040 MA A 1 I2

KEEP READING >>>

SEQ# 0000540 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000008
DHS 8500 (Rev. 02/98) 9999999999/MA A/01 NOTICE TYPE: AE01I2

AG Name:	Case Number:	Mailing Date:
JANE DOE	9999999999	03/11/1999

This "Important 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.

Ask for a State Hearing if you want to appeal.

Ask for a State Hearing if you disagree with what we are doing or think we are making a mistake. At the state hearing, you can explain your reasons. We will explain our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

We must get your request for a State Hearing by the deadline: 07/06/1999.

Please use the next page ("State Hearing Request") to ask for a State Hearing. Save all the other pages of this notice.

Someone else may help you (a lawyer, social worker, friend, relative, etc.). Someone else may request a hearing for you and come to the hearing with you.

You can also get information about free legal services. For free legal help call the Ohio State Legal Services Association at 1-800-589-5888 (a free call).

AG Name:	Case Number:	Mailing Date:
JANE DOE	9999999999	03/11/1999

STATE HEARING REQUEST

Get this to us by the deadline to ask for a State Hearing!

STEP 1 *Check all the boxes that apply, then sign.*

I want a State Hearing. I am most concerned about (optional):

- ☐ Checks or cash assistance (OWF or DA)
- ☐ Food Stamps
- ☐ Medical assistance (Medicaid, Medicare, LIF, Healthy Start, DA Medical, spenddown, nursing homes, QMB, SLMB, etc.)
- ☐ PRC
- ☐ Other (please explain):_____

(examples: child day care, child support, overpayments, etc.)

☐ I also want a County Conference. (A county conference is a meeting with you and staff from our county department of human services.)

My signature:_____ Date:_____ Phone: (___)_____

STEP 2 *You must complete this part if someone else is helping you with your case (a lawyer, social worker, friend, relative, etc.)*

My authorized representative is:

Name:_____Phone: (___)_____

Address:_____ Fax: (___)_____

_____ E-mail:_____

STEP 3 *Choose one of these ways to send this request to us. We must get this request by the deadline!*

MAIL: Mail only this page. Follow the steps on the back of this page.

FAX: Fax only this side of this page to 614-728-9574 (ODHS Bureau of State Hearings).

E-MAIL: E-mail to "bsh@odhs.state.oh.us". Please include all the information requested in Steps 1 and 2; and all the information from box at the top of this notice (AG Name, Case Number and Mailing Date).

VISIT OR PHONE YOUR CASEWORKER: It is better to ask for a hearing by using mail, fax or e-mail. You may visit or phone your caseworker. Ask for a "State Hearing." Only you may phone. Take all pages of this notice if you visit your caseworker. Mention this notice if you phone.

KEEP READING >>>

Mailing Steps:
(1) Fold this page only along the dotted lines.
(2) Tape or staple after folding.

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL
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POSTAGE WILL BE PAID BY ADDRESSEE

OHIO DEPARTMENT OF HUMAN SERVICES
BUREAU OF STATE HEARINGS
P.O. BOX 182825
COLUMBUS, OHIO 43272-5376

END

PRINT SEQ. 0000008

Client Notice: AE01-I3

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	July, 2000

Description of Notice:	Decrease in Medicaid nursing home patient liability
Assistance Categories:	MA (A, B, D, L, D)
Hearing Rights:	Yes
Program ID:	GAE501
Transaction ID:	Authorization
Frequency:	Daily
Volume (est. monthly):	7000
Form Number:	DHS 8500

Notes:

WCLM 1106

0000006

IMPORTANT NOTICE

MARION COUNTY DEPT OF HUMAN SERVICES
363 W. FAIRGROUND ST.
P.O. BOX 1817
MARION OH 433020000

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 04/05/1999
From: CHERYL L CARTER
Phone: (740) 387-8560 Ext: 0252

Worker ID: WCLM51
Case Number: 9999999999
AG Name: JANE DOE

Dear JANE DOE

We will LOWER your MEDICAID FOR THE AGED patient liability from $264 to $261 each month starting 05/01/1999.
If you have paid for medical services while eligible for Medicaid, you may be able to get your money back. For information call the Medicaid Consumer Hotline at 1-800-324-8680 or TDD 1-800-292-3572.

The people affected by this action are:
JOHN D (ELIGIBLE) JANE D (INELIGIBLE)

Reason: INCREASE IN INCOME RESULTS IN HIGHER PATIENT LIABILITY
We based this action on OHIO ADMINISTRATIVE CODE, Rule 07542

Reason: ALL ELIGIBILITY REQUIREMENTS HAVE BEEN MET
We based this action on OHIO ADMINISTRATIVE CODE, Rule 01020

RC: 451 091 MA A 2 I3

KEEP READING >>>

SEQ# 0000367 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000006
DHS 8500 (Rev. 02/98) 9999999999/MA A/02 NOTICE TYPE: AE01I3

AG Name:	Case Number:	Mailing Date:
JANE DOE	9999999999	04/05/1999

This "Important 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.

Ask for a State Hearing if you want to appeal.

Ask for a State Hearing if you disagree with what we are doing or think we are making a mistake. At the state hearing, you can explain your reasons. We will explain our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

We must get your request for a State Hearing by the deadline: 06/28/2000.

Please use the next page ("State Hearing Request") to ask for a State Hearing. Save all the other pages of this notice.

Someone else may help you (a lawyer, social worker, friend, relative, etc.). Someone else may request a hearing for you and come to the hearing with you.

You can also get information about free legal services. For free legal help call the Ohio State Legal Services Association at 1-800-589-5888 (a free call).

AG Name:	Case Number:	Mailing Date:
JANE DOE	9999999999	04/05/1999

STATE HEARING REQUEST

Get this to us by the deadline to ask for a State Hearing!

STEP 1 *Check all the boxes that apply, then sign.*

I want a State Hearing. I am most concerned about (optional):

- ☐ Checks or cash assistance (OWF or DA)
- ☐ Food Stamps
- ☐ Medical assistance (Medicaid, Medicare, LIF, Healthy Start, DA Medical, spenddown, nursing homes, QMB, SLMB, etc.)
- ☐ PRC
- ☐ Other (please explain):_____

(examples: child day care, child support, overpayments, etc.)

☐ I also want a County Conference. (A county conference is a meeting with you and staff from our county department of human services.)

My signature:_____ Date:_____ Phone: (___)_____

STEP 2 *You must complete this part if someone else is helping you with your case (a lawyer, social worker, friend, relative, etc.)*

My authorized representative is:

Name:_____Phone: (___)_____

Address:_____ Fax: (___)_____

_____ E-mail:_____

STEP 3 *Choose one of these ways to send this request to us. We must get this request by the deadline!*

MAIL: Mail only this page. Follow the steps on the back of this page.

FAX: Fax only this side of this page to 614-728-9574 (ODHS Bureau of State Hearings).

E-MAIL: E-mail to "bsh@odhs.state.oh.us". Please include all the information requested in Steps 1 and 2; and all the information from box at the top of this notice (AG Name, Case Number and Mailing Date).

VISIT OR PHONE YOUR CASEWORKER: It is better to ask for a hearing by using mail, fax or e-mail. You may visit or phone your caseworker. Ask for a "State Hearing." Only you may phone. Take all pages of this notice if you visit your caseworker. Mention this notice if you phone.

KEEP READING >>>

Mailing Steps:
(1) Fold this page only along the dotted lines.
(2) Tape or staple after folding.

JANE DEO
111 MAIN ST

ANYWHERE OH 99999-9999

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO 5249 COLUMBUS OH

POSTAGE WILL BE PAID BY ADDRESSEE

OHIO DEPARTMENT OF HUMAN SERVICES
BUREAU OF STATE HEARINGS
P.O. BOX 182825
COLUMBUS, OHIO 43272-5376

END

PRINT SEQ. 0000006

Client Notice: AE01-M1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	July, 2000

Description of Notice:	Notice of no change in benefit although there has been a change in eligible individuals.
Assistance Categories:	MA-Y,-C,-H,-P,-Q,-S,-T,-V,-W,-X,-Z,-G, MAYP, -CP,-HP,-PP,-SP,-TP,-VP,-WP,-XP,-ZP,MAGP, ADC, GA
Hearing Rights:	Yes
Program ID:	GAE501
Transaction ID:	Authorization
Frequency:	Daily
Volume (est. monthly):	8000
Form Number:	DHS 8500
Notes:	The General Assistance was discontinued as of 7/31/95.

WJMK 0303

0000005

IMPORTANT NOTICE

FAIRFIELD COUNTY DEPT OF HUMAN SERVICES
P.O. BOX 890

LANCASTER OH 431300000

JANE DOE
111 MAIN TS

ANYWHERE OH 99999-9999

Mailing Date: 03/30/2000
From: JEANNE M KELL
Phone: (614) 653-1701 Ext:

Worker ID: WJMK23
Case Number: 9999999999
AG Name: JANE DOE

Dear JANE DOE

We will STOP HEALTHY START on 04/30/2000 for the people marked "(INELIGIBLE)" or who are no longer in the assistance group. We will CONTINUE or START HEALTHY START for the people marked "(ELIGIBLE)".
If you have paid for medical services while eligible for Medicaid, you may be able to get your money back. For information call the Medicaid Consumer Hotline at 1-800-324-8680 or TDD 1-800-292-3572.

The people affected by this action are:
JOHN D (INELIGIBLE) JANE D (ELIGIBLE) JANE D (INELIGIBLE) JOHN D (ELIGIBLE)

Reason: EXPIRED POST-PARTUM PERIOD
We based this action on OHIO ADMINISTRATIVE CODE, Rule 11223

Reason: ALL ELIGIBILITY REQUIREMENTS HAVE BEEN MET
We based this action on OHIO ADMINISTRATIVE CODE, Rule 5101:1-2-10

RC: 558 091 MA P 1 M1

KEEP READING >>>

SEQ# 0000040 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000005
DHS 8500 (Rev. 02/98) 9999999999/MA P/01 NOTICE TYPE: AE01M1

AG Name:	Case Number:	Mailing Date:
JANE DOE	9999999999	03/30/2000

This "Important 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.

Ask for a State Hearing if you want to appeal.

Ask for a State Hearing if you disagree with what we are doing or think we are making a mistake. At the state hearing, you can explain your reasons. We will explain our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

- **The first deadline is 04/14/2000. We will not stop or lower your benefits before your hearing if we get your hearing request by the first deadline.** (However, if you lose the hearing, you may have to repay any benefits you were not eligible to get.)
- The final deadline is 06/28/2000. If we get your hearing request after the first deadline, we will stop or lower your benefits before the hearing. You may still have a hearing but only if we get your request by the final deadline.

Please use the next page ("State Hearing Request") to ask for a State Hearing. Save all the other pages of this notice.

Someone else may help you (a lawyer, social worker, friend, relative, etc.). Someone else may request a hearing for you and come to the hearing with you.

You can also get information about free legal services. For free legal help call the Ohio State Legal Services Association at 1-800-589-5888 (a free call).

AG Name:	Case Number:	Mailing Date:
JANE DOE	9999999999	03/30/2000

STATE HEARING REQUEST

Get this to us by the deadline to ask for a State Hearing!

STEP 1 *Check all the boxes that apply, then sign.*

I want a State Hearing. I am most concerned about (optional):

- ☐ Checks or cash assistance (OWF or DA)
- ☐ Food Stamps
- ☐ Medical assistance (Medicaid, Medicare, LIF, Healthy Start, DA Medical, spenddown, nursing homes, QMB, SLMB, etc.)
- ☐ PRC
- ☐ Other (please explain):_____

(examples: child day care, child support, overpayments, etc.)

☐ I also want a County Conference. (A county conference is a meeting with you and staff from our county department of human services.)

My signature:_____ Date:_____ Phone: (___)_____

STEP 2 *You must complete this part if someone else is helping you with your case (a lawyer, social worker, friend, relative, etc.)*

My authorized representative is:

Name:_____Phone: (___)_____

Address:_____ Fax: (___)_____

_____ E-mail:_____

STEP 3 *Choose one of these ways to send this request to us. We must get this request by the deadline!*

MAIL: Mail only this page. Follow the steps on the back of this page.

FAX: Fax only this side of this page to 614-728-9574 (ODHS Bureau of State Hearings).

E-MAIL: E-mail to "bsh@odhs.state.oh.us". Please include all the information requested in Steps 1 and 2; and all the information from box at the top of this notice (AG Name, Case Number and Mailing Date).

VISIT OR PHONE YOUR CASEWORKER: It is better to ask for a hearing by using mail, fax or e-mail. You may visit or phone your caseworker. Ask for a "State Hearing." Only you may phone. Take all pages of this notice if you visit your caseworker. Mention this notice if you phone.

KEEP READING >>>

Mailing Steps:
(1) Fold this page only along the dotted lines.
(2) Tape or staple after folding.

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO 5249 COLUMBUS OH

POSTAGE WILL BE PAID BY ADDRESSEE

OHIO DEPARTMENT OF HUMAN SERVICES
BUREAU OF STATE HEARINGS
P.O. BOX 182825
COLUMBUS, OHIO 43272-5376

END

PRINT SEQ. 0000005

Client Notice: AE01-R1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	July, 2000

Description of Notice:	Decrease in benefits
Assistance Categories:	All Categories
Hearing Rights:	Yes
Program ID:	GAE501
Transaction ID:	Authorization
Frequency:	Daily
Volume (est. monthly):	36989
Form Number:	DHS 8500

Notes:

WMAM 0062

0000001

IMPORTANT NOTICE

FAIRFIELD COUNTY DEPT OF HUMAN SERVICES
P.O. BOX 890

LANCASTER OH 431300000

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 03/11/1999
From: MARGARET A MOHLER
Phone: (614) 653-1701 Ext: 6808

Worker ID: WMAM23
Case Number: 9999999999
AG Name: JANE DOE

Dear JANE DOE

We will LOWER your FOOD STAMP from $230 to $150 each month starting 04/01/1999.

The people affected by this action are:
JANE D (ELIGIBLE) JANE D (ELIGIBLE)

Reason:
THE ASSISTANCE GROUP SHELTER COSTS HAVE DECREASED FROM $ 450.00 TO $ 139.00 .
We based this action on OHIO ADMINISTRATIVE CODE, Rule 5101:4-4-23

Reason: ALL ELIGIBILITY REQUIREMENTS HAVE BEEN MET
We based this action on OHIO ADMINISTRATIVE CODE, Rule 5101:4-5-07

RC: 417 091 FS 1 R1

KEEP READING >>>

SEQ# 0000003 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000001
DHS 8500 (Rev. 02/98) 9999999999/FS /01 NOTICE TYPE: AE01R1

AG Name:	Case Number:	Mailing Date:
JANE DOE	9999999999	03/11/1999

This "Important 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.

Ask for a State Hearing if you want to appeal.

Ask for a State Hearing if you disagree with what we are doing or think we are making a mistake. At the state hearing, you can explain your reasons. We will explain our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

- **The first deadline is 03/26/1999. We will not stop or lower your benefits before your hearing if we get your hearing request by the first deadline.** (However, if you lose the hearing, you may have to repay any benefits you were not eligible to get.)
- The final deadline is 06/09/1999. If we get your hearing request after the first deadline, we will stop or lower your benefits before the hearing. You may still have a hearing but only if we get your request by the final deadline.

Please use the next page ("State Hearing Request") to ask for a State Hearing. Save all the other pages of this notice.

Someone else may help you (a lawyer, social worker, friend, relative, etc.). Someone else may request a hearing for you and come to the hearing with you.

You can also get information about free legal services. For free legal help call the Ohio State Legal Services Association at 1-800-589-5888 (a free call).

AG Name:	Case Number:	Mailing Date:
JANE DOE	9999999999	03/11/1999

STATE HEARING REQUEST

Get this to us by the deadline to ask for a State Hearing!

STEP 1 *Check all the boxes that apply, then sign.*

I want a State Hearing. I am most concerned about (optional):

- ☐ Checks or cash assistance (OWF or DA)
- ☐ Food Stamps
- ☐ Medical assistance (Medicaid, Medicare, LIF, Healthy Start, DA Medical, spenddown, nursing homes, QMB, SLMB, etc.)
- ☐ PRC
- ☐ Other (please explain):_____

(examples: child day care, child support, overpayments, etc.)

☐ I also want a County Conference. (A county conference is a meeting with you and staff from our county department of human services.)

My signature:_____ Date:_____ Phone: (___)_____

STEP 2 *You must complete this part if someone else is helping you with your case (a lawyer, social worker, friend, relative, etc.)*

My authorized representative is:

Name:_____Phone: (___)_____

Address:_____ Fax: (___)_____

_____ E-mail:_____

STEP 3 *Choose one of these ways to send this request to us. We must get this request by the deadline!*

MAIL: Mail only this page. Follow the steps on the back of this page.

FAX: Fax only this side of this page to 614-728-9574 (ODHS Bureau of State Hearings).

E-MAIL: E-mail to "bsh@odhs.state.oh.us". Please include all the information requested in Steps 1 and 2; and all the information from box at the top of this notice (AG Name, Case Number and Mailing Date).

VISIT OR PHONE YOUR CASEWORKER: It is better to ask for a hearing by using mail, fax or e-mail. You may visit or phone your caseworker. Ask for a "State Hearing." Only you may phone. Take all pages of this notice if you visit your caseworker. Mention this notice if you phone.

KEEP READING >>>

Mailing Steps:
(1) Fold this page only along the dotted lines.
(2) Tape or staple after folding.

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO 5249 COLUMBUS OH

POSTAGE WILL BE PAID BY ADDRESSEE

OHIO DEPARTMENT OF HUMAN SERVICES
BUREAU OF STATE HEARINGS
P.O. BOX 182825
COLUMBUS, OHIO 43272-5376

END

PRINT SEQ. 0000001

Client Notice: AE01-R2

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	July, 2000

Description of Notice:	Increase in Medicaid spenddown liability
Assistance Categories:	MA only
Hearing Rights:	Yes
Program ID:	GAE501
Transaction ID:	Authorization
Frequency:	Daily
Volume (est. monthly):	5000
Form Number:	DHS 8500

Notes:

WBSD 0032

0000003

IMPORTANT NOTICE

FAIRFIELD COUNTY DEPT OF HUMAN SERVICES
P.O. BOX 890

LANCASTER OH 431300000

JOHN DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 03/11/1999
From: BARBARA D DENNIS
Phone: (614) 653-1701 Ext:

Worker ID: WBSD23
Case Number: 9999999999
AG Name: JOHN DOE

Dear JOHN DOE

We will RAISE your MEDICAID FOR THE AGED spenddown from $174 to $187 each month starting 04/01/1999.
If you have paid for medical services while eligible for Medicaid, you may be able to get your money back. For information call the Medicaid Consumer Hotline at 1-800-324-8680 or TDD 1-800-292-3572.

The people affected by this action are:
JANE D (INELIGIBLE) JOHN D (INELIGIBLE)

Reason: FAILURE TO MEET SPENDDOWN LIABILITY
We based this action on OHIO ADMINISTRATIVE CODE, Rule 07467

Reason: MEDICAID ELIGIBILITY APPROVED ON A DELAYED SPEND-DOWN BASIS
We based this action on OHIO ADMINISTRATIVE CODE, Rule 07467

RC: 403 040 MA A 1 R2

KEEP READING >>>

SEQ# 0000039 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000003
DHS 8500 (Rev. 02/98) 9999999999/MA A/01 NOTICE TYPE: AE01R2

AG Name:	Case Number:	Mailing Date:
JOHN DOE	9999999999	03/11/1999

This "Important 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.

Ask for a State Hearing if you want to appeal.

Ask for a State Hearing if you disagree with what we are doing or think we are making a mistake. At the state hearing, you can explain your reasons. We will explain our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

- **The first deadline is 04/20/1999. We will not stop or lower your benefits before your hearing if we get your hearing request by the first deadline.** (However, if you lose the hearing, you may have to repay any benefits you were not eligible to get.)
- The final deadline is 07/06/1999. If we get your hearing request after the first deadline, we will stop or lower your benefits before the hearing. You may still have a hearing but only if we get your request by the final deadline.

Please use the next page ("State Hearing Request") to ask for a State Hearing. Save all the other pages of this notice.

Someone else may help you (a lawyer, social worker, friend, relative, etc.). Someone else may request a hearing for you and come to the hearing with you.

You can also get information about free legal services. For free legal help call the Ohio State Legal Services Association at 1-800-589-5888 (a free call).

AG Name:	Case Number:	Mailing Date:
JOHN DOE	9999999999	03/11/1999

STATE HEARING REQUEST

Get this to us by the deadline to ask for a State Hearing!

STEP 1 *Check all the boxes that apply, then sign.*

I want a State Hearing. I am most concerned about (optional):

- ☐ Checks or cash assistance (OWF or DA)
- ☐ Food Stamps
- ☐ Medical assistance (Medicaid, Medicare, LIF, Healthy Start, DA Medical, spenddown, nursing homes, QMB, SLMB, etc.)
- ☐ PRC
- ☐ Other (please explain):_____

(examples: child day care, child support, overpayments, etc.)

☐ I also want a County Conference. (A county conference is a meeting with you and staff from our county department of human services.)

My signature:_____ Date:_____ Phone: (___)_____

STEP 2 *You must complete this part if someone else is helping you with your case (a lawyer, social worker, friend, relative, etc.)*

My authorized representative is:

Name:_____Phone: (___)_____

Address:_____ Fax: (___)_____

_____ E-mail:_____

STEP 3 *Choose one of these ways to send this request to us. We must get this request by the deadline!*

MAIL: Mail only this page. Follow the steps on the back of this page.

FAX: Fax only this side of this page to 614-728-9574 (ODHS Bureau of State Hearings).

E-MAIL: E-mail to "bsh@odhs.state.oh.us". Please include all the information requested in Steps 1 and 2; and all the information from box at the top of this notice (AG Name, Case Number and Mailing Date).

VISIT OR PHONE YOUR CASEWORKER: It is better to ask for a hearing by using mail, fax or e-mail. You may visit or phone your caseworker. Ask for a "State Hearing." Only you may phone. Take all pages of this notice if you visit your caseworker. Mention this notice if you phone.

KEEP READING >>>

Mailing Steps:
(1) Fold this page only along the dotted lines.
(2) Tape or staple after folding.

JOHN DOE
111 MAIN ST

ANYWHERE OH 99999-9999

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO 5249 COLUMBUS OH

POSTAGE WILL BE PAID BY ADDRESSEE

OHIO DEPARTMENT OF HUMAN SERVICES
BUREAU OF STATE HEARINGS
P.O. BOX 182825
COLUMBUS, OHIO 43272-5376

END

PRINT SEQ. 0000003

Client Notice: AE01-R3

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	July, 2000

Description of Notice:	Increase in Medicaid nursing home patient liability.
Assistance Categories:	MA (A, B, D)
Hearing Rights:	Yes
Program ID:	GAE501
Transaction ID:	Authorization
Frequency:	Daily
Volume (est. monthly):	30000
Form Number:	DHS 8500

Notes:

WVAW 0025

0000004

IMPORTANT NOTICE

FAIRFIELD COUNTY DEPT OF HUMAN SERVICES
P.O. BOX 890

LANCASTER OH 431300000

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 04/05/1999
From: VICTORIA A WINKELMAN
Phone: (614) 653-1701 Ext:

Worker ID: WVAW23
Case Number: 9999999999
AG Name: JANE DOE

Dear JANE DOE

We will RAISE your MEDICAID FOR THE AGED patient liability from $1,776 to$1,796 each month starting 05/01/1999.
If you have paid for medical services while eligible for Medicaid, you may be able to get your money back. For information call the Medicaid Consumer Hotline at 1-800-324-8680 or TDD 1-800-292-3572.

The people affected by this action are:
JANE D (ELIGIBLE) JOHN D (INELIGIBLE)

Reason: INCREASE IN INCOME RESULTS IN HIGHER PATIENT LIABILITY
We based this action on OHIO ADMINISTRATIVE CODE, Rule 07542

Reason: ALL ELIGIBILITY REQUIREMENTS HAVE BEEN MET
We based this action on OHIO ADMINISTRATIVE CODE, Rule 01020

RC: 451 091 MA A 1 R3

KEEP READING >>>

SEQ# 0000069 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000004
DHS 8500 (Rev. 02/98) 9999999999/MA A/01 NOTICE TYPE: AE01R3

AG Name:	Case Number:	Mailing Date:
JANE DOE	9999999999	04/05/1999

This "Important 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.

Ask for a State Hearing if you want to appeal.

Ask for a State Hearing if you disagree with what we are doing or think we are making a mistake. At the state hearing, you can explain your reasons. We will explain our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

- **The first deadline is 04/12/1999. We will not stop or lower your benefits before your hearing if we get your hearing request by the first deadline.** (However, if you lose the hearing, you may have to repay any benefits you were not eligible to get.)
- The final deadline is 06/24/1999. If we get your hearing request after the first deadline, we will stop or lower your benefits before the hearing. You may still have a hearing but only if we get your request by the final deadline.

Please use the next page ("State Hearing Request") to ask for a State Hearing. Save all the other pages of this notice.

Someone else may help you (a lawyer, social worker, friend, relative, etc.). Someone else may request a hearing for you and come to the hearing with you.

You can also get information about free legal services. For free legal help call the Ohio State Legal Services Association at 1-800-589-5888 (a free call).

AG Name:	Case Number:	Mailing Date:
JANE DOE	9999999999	04/05/1999

STATE HEARING REQUEST

Get this to us by the deadline to ask for a State Hearing!

STEP 1 *Check all the boxes that apply, then sign.*

I want a State Hearing. I am most concerned about (optional):

- ☐ Checks or cash assistance (OWF or DA)
- ☐ Food Stamps
- ☐ Medical assistance (Medicaid, Medicare, LIF, Healthy Start, DA Medical, spenddown, nursing homes, QMB, SLMB, etc.)
- ☐ PRC
- ☐ Other (please explain):_____

(examples: child day care, child support, overpayments, etc.)

☐ I also want a County Conference. (A county conference is a meeting with you and staff from our county department of human services.)

My signature:_____ Date:_____ Phone: (___)_____

STEP 2 *You must complete this part if someone else is helping you with your case (a lawyer, social worker, friend, relative, etc.)*

My authorized representative is:

Name:_____Phone: (___)_____

Address:_____ Fax: (___)_____

_____ E-mail:_____

STEP 3 *Choose one of these ways to send this request to us. We must get this request by the deadline!*

MAIL: Mail only this page. Follow the steps on the back of this page.

FAX: Fax only this side of this page to 614-728-9574 (ODHS Bureau of State Hearings).

E-MAIL: E-mail to "bsh@odhs.state.oh.us". Please include all the information requested in Steps 1 and 2; and all the information from box at the top of this notice (AG Name, Case Number and Mailing Date).

VISIT OR PHONE YOUR CASEWORKER: It is better to ask for a hearing by using mail, fax or e-mail. You may visit or phone your caseworker. Ask for a "State Hearing." Only you may phone. Take all pages of this notice if you visit your caseworker. Mention this notice if you phone.

KEEP READING >>>

Mailing Steps:
(1) Fold this page only along the dotted lines.
(2) Tape or staple after folding.

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO 5249 COLUMBUS OH

POSTAGE WILL BE PAID BY ADDRESSEE

OHIO DEPARTMENT OF HUMAN SERVICES
BUREAU OF STATE HEARINGS
P.O. BOX 182825
COLUMBUS, OHIO 43272-5376

END

PRINT SEQ. 0000004

Client Notice: AE01-T1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:

Date Implemented: 8/1/96

Last Date Revised: July, 2000

Description of Notice: Termination of Benefits

Assistance Categories: All but MAA, MAB & MAD w/spenddown > 0

Hearing Rights: Yes

Program ID: GAE501, GBI050, GCU023, GPR004

Transaction ID: Authorization

Frequency: Daily

Volume (est. monthly): 117170

Form Number: DHS 8500

Notes:

WMJS 0052

0000007

IMPORTANT NOTICE

HAMILTON COUNTY DEPT OF HUMAN SERVICES
222 E. CENTRAL PARKWAY

CINCINNATI OH 452020000

JOHN DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 03/26/1999
From: MRS. M STRICKER
Phone: (513) 946-1094 Ext:

Worker ID: WMJS31
Case Number: 9999999999
AG Name: JOHN DOE

Dear JOHN DOE

We will STOP your OHIO WORKS FIRST (OWF) on 04/30/1999.

The people affected by this action are:
JOHN D (INELIGIBLE) JOHN D (INELIGIBLE) JOHN D (INELIGIBLE)

Reason:
FOR A FIRST FAILURE, YOU ARE NOT ELIGIBLE FOR AT LEAST 1 MONTH. INFORMATION BELOW TELLS HOW YOU FAILED AND WHAT MUST BE DONE TO END THE SANCTION. THE FOLLOWING PEOPLE FAILED TO COMPLY: JOHN DOE
We based this action on OHIO REVISED CODE, Section 5107.14

RC: 628 ADCR 1 T1

KEEP READING >>>

SEQ# 0000190 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000007
DHS 8500 (Rev. 02/98) 9999999999/ADCR/01 NOTICE TYPE: AE01T1

TRANSITIONAL MEDICAID AND CHILD CARE

If you get a job, you may still be eligible for Medicaid benefits even though your income may be too high to continue to receive cash assistance under the Ohio Works First (OWF) program or Medicaid under the Low-Income Families (LIF) program. Listed below are some of the most commonly asked question about Transitional Medicaid Care.

What is Transitional Medicaid?

Transitional Medicaid is a program that provides up to two 6-month periods of Medicaid coverage.

Who is eligible for the first six months?

OWF or LIF assistance groups are eligible for the first 6 months if:

1. Loss of OWF or LIF eligibility was due to income from employment of the parent or specified relative; or due to the expiration of the $250 and one-half disregard; and

2. OWF or LIF was received in 3 out of the last 6 calendar months; and

3. Includes a child under 18 or has not attained 19 years of age and is a full-time student in a secondary school or in the equivalent level of vocational or technical training; and

4. No member of the assistance group has been convicted of OWF or Medicaid fraud within the 6 month period prior to OWF ineligibility.

Who is eligible for the second six months?

OWF or LIF assistance groups are eligible for the second 6 months if:

1. Transitional Medicaid was received during the entire initial 6 month period; and

2. Includes a child under 18 or has not attained 19 years of age and is a full-time student in a secondary school or in the equivalent level of vocational or technical; and

3. Submit quarterly reports; and

4. The average monthly earnings (less child care costs) do not exceed 185% of the federal poverty level; and

5. The parent or specified relative reported earnings for every month covered by the quarterly reports.

How do I apply for Transitional Medicaid?

When your OWF or LIF assistance is terminated for any reason, your caseworker will review your case record, determine Transitional Medicaid eligibility, and notify you if you are eligible. You will also be notified of your reporting responsibilities.

REPORTING CHANGES

When should I report to my caseworker about a new job or change in my job?

You should report changes to your caseworker as soon as possible, but no later than 10 days after the change has occurred. Changes you must report include if you change jobs, move, someone moves into or out of your household, or if your income or the hours you work change.

HEARING RIGHTS

What if my OWF or LIF was closed for a reason other than employment but I think I am still eligible for Transitional Medicaid?

If you think you may be eligible for Transitional Medicaid, but you have not heard from your caseworker, you should contact the county department of human services to find out if a decision was made about your eligibility for Transitional Medicaid.

What if a family does not agree with a decision made by the County Department of Human Services on whether the family is eligible for Transitional Medicaid?

If a family member does not agree with an action or decision made by the County Department of Human Services, a hearing can be requested. The hearing officer will listen to both sides, then a written decision will be sent to the family and the agency.

AG Name:	Case Number:	Mailing Date:
JOHN DOE	9999999999	03/26/1999

This "Important 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.

Ask for a State Hearing if you want to appeal.

Ask for a State Hearing if you disagree with what we are doing or think we are making a mistake. At the state hearing, you can explain your reasons. We will explain our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

- **The first deadline is 03/26/1999. We will not stop or lower your benefits before your hearing if we get your hearing request by the first deadline.** (However, if you lose the hearing, you may have to repay any benefits you were not eligible to get.)
- The final deadline is 06/09/1999. If we get your hearing request after the first deadline, we will stop or lower your benefits before the hearing. You may still have a hearing but only if we get your request by the final deadline.

Please use the next page ("State Hearing Request") to ask for a State Hearing. Save all the other pages of this notice.

Someone else may help you (a lawyer, social worker, friend, relative, etc.). Someone else may request a hearing for you and come to the hearing with you.

You can also get information about free legal services. For free legal help call the Ohio State Legal Services Association at 1-800-589-5888 (a free call).

AG Name:	Case Number:	Mailing Date:
JOHN DOE	9999999999	03/26/1999

STATE HEARING REQUEST

Get this to us by the deadline to ask for a State Hearing!

STEP 1 *Check all the boxes that apply, then sign.*

I want a State Hearing. I am most concerned about (optional):

- ☐ Checks or cash assistance (OWF or DA)
- ☐ Food Stamps
- ☐ Medical assistance (Medicaid, Medicare, LIF, Healthy Start, DA Medical, spenddown, nursing homes, QMB, SLMB, etc.)
- ☐ PRC
- ☐ Other (please explain):_____

(examples: child day care, child support, overpayments, etc.)

☐ I also want a County Conference. (A county conference is a meeting with you and staff from our county department of human services.)

My signature:_____ Date:_____ Phone: (___)_____

STEP 2 *You must complete this part if someone else is helping you with your case (a lawyer, social worker, friend, relative, etc.)*

My authorized representative is:

Name:_____Phone: (___)_____

Address:_____ Fax: (___)_____

_____ E-mail:_____

STEP 3 *Choose one of these ways to send this request to us. We must get this request by the deadline!*

MAIL: Mail only this page. Follow the steps on the back of this page.

FAX: Fax only this side of this page to 614-728-9574 (ODHS Bureau of State Hearings).

E-MAIL: E-mail to "bsh@odhs.state.oh.us". Please include all the information requested in Steps 1 and 2; and all the information from box at the top of this notice (AG Name, Case Number and Mailing Date).

VISIT OR PHONE YOUR CASEWORKER: It is better to ask for a hearing by using mail, fax or e-mail. You may visit or phone your caseworker. Ask for a "State Hearing." Only you may phone. Take all pages of this notice if you visit your caseworker. Mention this notice if you phone.

KEEP READING >>>

Mailing Steps:
(1) Fold this page only along the dotted lines.
(2) Tape or staple after folding.

JOHN DOE
111 MAIN ST

ANYWHERE OH 99999-9999

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO 5249 COLUMBUS OH

POSTAGE WILL BE PAID BY ADDRESSEE

OHIO DEPARTMENT OF HUMAN SERVICES
BUREAU OF STATE HEARINGS
P.O. BOX 182825
COLUMBUS, OHIO 43272-5376

END

PRINT SEQ. 0000007

Client Notice: AE01-T2

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:

Date Implemented: N/A

Last Date Revised: July, 2000

Description of Notice: Termination of Medicaid, with explanation of possible spenddown eligibility

Assistance Categories: MA (A, B, D, L) with spenddown amount > 0

Hearing Rights: Yes

Program ID: GAE501

Transaction ID: Authorization

Frequency: Daily

Volume (est. monthly): 2800

Form Number: DHS 8500

Notes: AG ADCR comes with Transitional Medicaid page attacthed.

WDGJ 0021

0000002

IMPORTANT NOTICE

FAIRFIELD COUNTY DEPT OF HUMAN SERVICES
P.O. BOX 890

LANCASTER OH 431300000

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 03/11/1999
From: DENNIS G JOHNSON
Phone: (614) 653-1701 Ext:

Worker ID: WDGJ23
Case Number: 9999999999
AG Name: JANE DOE

Dear JANE DOE

Your MEDICAID FOR THE AGED benefits will be STOPPED effective 03/31/1999 unless you continue to be eligible for a Medicaid card as a spenddown recipient. If you can prove to the county department of human services that you have $321 of medical expenses each month, your medical card will be released to you.

The people affected by this action are:
JANE D (INELIGIBLE)

Reason: VALUE OF RESOURCES EXCEEDS PROGRAM ELIGIBILITY LIMITS
We based this action on OHIO ADMINISTRATIVE CODE, Rule 07412

Reason: FAILURE TO MEET SPENDDOWN LIABILITY
We based this action on OHIO ADMINISTRATIVE CODE, Rule 07467

RC: 386 403 MA A 1 T2

KEEP READING >>>

SEQ# 0000005 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000002
DHS 8500 (Rev. 02/98) 9999999999/MA A/01 NOTICE TYPE: AE01T2

AG Name:	Case Number:	Mailing Date:
JANE DOE	9999999999	03/11/1999

This "Important 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.

Ask for a State Hearing if you want to appeal.

Ask for a State Hearing if you disagree with what we are doing or think we are making a mistake. At the state hearing, you can explain your reasons. We will explain our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

- **The first deadline is 04/20/1999. We will not stop or lower your benefits before your hearing if we get your hearing request by the first deadline.** (However, if you lose the hearing, you may have to repay any benefits you were not eligible to get.)
- The final deadline is 07/06/1999. If we get your hearing request after the first deadline, we will stop or lower your benefits before the hearing. You may still have a hearing but only if we get your request by the final deadline.

Please use the next page ("State Hearing Request") to ask for a State Hearing. Save all the other pages of this notice.

Someone else may help you (a lawyer, social worker, friend, relative, etc.). Someone else may request a hearing for you and come to the hearing with you.

You can also get information about free legal services. For free legal help call the Ohio State Legal Services Association at 1-800-589-5888 (a free call).

AG Name:	Case Number:	Mailing Date:
JANE DOE	9999999999	03/11/1999

STATE HEARING REQUEST

Get this to us by the deadline to ask for a State Hearing!

STEP 1 *Check all the boxes that apply, then sign.*

I want a State Hearing. I am most concerned about (optional):

- ☐ Checks or cash assistance (OWF or DA)
- ☐ Food Stamps
- ☐ Medical assistance (Medicaid, Medicare, LIF, Healthy Start, DA Medical, spenddown, nursing homes, QMB, SLMB, etc.)
- ☐ PRC
- ☐ Other (please explain):_____

(examples: child day care, child support, overpayments, etc.)

☐ I also want a County Conference. (A county conference is a meeting with you and staff from our county department of human services.)

My signature:_____ Date:_____ Phone: (___)_____

STEP 2 *You must complete this part if someone else is helping you with your case (a lawyer, social worker, friend, relative, etc.)*

My authorized representative is:

Name:_____Phone: (___)_____

Address:_____ Fax: (___)_____

_____ E-mail:_____

STEP 3 *Choose one of these ways to send this request to us. We must get this request by the deadline!*

MAIL: Mail only this page. Follow the steps on the back of this page.

FAX: Fax only this side of this page to 614-728-9574 (ODHS Bureau of State Hearings).

E-MAIL: E-mail to "bsh@odhs.state.oh.us". Please include all the information requested in Steps 1 and 2; and all the information from box at the top of this notice (AG Name, Case Number and Mailing Date).

VISIT OR PHONE YOUR CASEWORKER: It is better to ask for a hearing by using mail, fax or e-mail. You may visit or phone your caseworker. Ask for a "State Hearing." Only you may phone. Take all pages of this notice if you visit your caseworker. Mention this notice if you phone.

KEEP READING >>>

Mailing Steps:
(1) Fold this page only along the dotted lines.
(2) Tape or staple after folding.

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO 5249 COLUMBUS OH

POSTAGE WILL BE PAID BY ADDRESSEE

OHIO DEPARTMENT OF HUMAN SERVICES
BUREAU OF STATE HEARINGS
P.O. BOX 182825
COLUMBUS, OHIO 43272-5376

END

PRINT SEQ. 0000002

Client Notice: AE01-X2

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	96134-15
Date Implemented:	N/A
Last Date Revised:	July, 2000

Description of Notice:	Notice of auxilliary check to correct underpayment
Assistance Categories:	ADC, GA, FS, MA (OSS)
Hearing Rights:	Yes
Program ID:	GAE501
Transaction ID:	Authorization
Frequency:	Daily
Volume (est. monthly):	500
Form Number:	DHS 8500
Notes:	Notice of auxilliary due to a delay in implementing the FS increase.

WCZM 2613

0000005

IMPORTANT NOTICE

FRANKLIN CO COC COUNTY DEPT OF HUMAN SERVICES
80 E. FULTON ST.

COLUMBUS OH 432150000

JOHN DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 04/05/1999
From: CHARLES L MARLOWE
Phone: (614) 462-3321 Ext:

Worker ID: WCZM25
Case Number: 9999999999
AG Name: JOHN DOE

Dear JOHN DOE

From 05/01/1999 through 05/31/1999 your assistance group received $362 less in OHIO WORKS FIRST (OWF) benefits than you should have received. You will receive an additional $362 in OHIO WORKS FIRST (OWF) benefits for that period.

The people affected by this action are:
JOHN D (ELIGIBLE) JANE D (ELIGIBLE) JOHN D (ELIGIBLE)

Reason: ALL ELIGIBILITY REQUIREMENTS HAVE BEEN MET
We based this action on OHIO ADMINISTRATIVE CODE, Rule 5101:1-2-10

RC: 091 ADCR 3 X2

KEEP READING >>>

SEQ# 0002035 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000005
DHS 8500 (Rev. 02/98) 9999999999/ADCR/03 NOTICE TYPE: AE01X2

AG Name:	Case Number:	Mailing Date:
JOHN DOE	9999999999	04/05/1999

This "Important 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.

Ask for a State Hearing if you want to appeal.

Ask for a State Hearing if you disagree with what we are doing or think we are making a mistake. At the state hearing, you can explain your reasons. We will explain our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

We must get your request for a State Hearing by the deadline: 07/06/1999.

Please use the next page ("State Hearing Request") to ask for a State Hearing. Save all the other pages of this notice.

Someone else may help you (a lawyer, social worker, friend, relative, etc.). Someone else may request a hearing for you and come to the hearing with you.

You can also get information about free legal services. For free legal help call the Ohio State Legal Services Association at 1-800-589-5888 (a free call).

AG Name:	Case Number:	Mailing Date:
JOHN DOE	9999999999	04/05/1999

STATE HEARING REQUEST

Get this to us by the deadline to ask for a State Hearing!

STEP 1 *Check all the boxes that apply, then sign.*

I want a State Hearing. I am most concerned about (optional):

- ☐ Checks or cash assistance (OWF or DA)
- ☐ Food Stamps
- ☐ Medical assistance (Medicaid, Medicare, LIF, Healthy Start, DA Medical, spenddown, nursing homes, QMB, SLMB, etc.)
- ☐ PRC
- ☐ Other (please explain):_____

(examples: child day care, child support, overpayments, etc.)

☐ I also want a County Conference. (A county conference is a meeting with you and staff from our county department of human services.)

My signature:_____ Date:_____ Phone: (___)_____

STEP 2 *You must complete this part if someone else is helping you with your case (a lawyer, social worker, friend, relative, etc.)*

My authorized representative is:

Name:_____Phone: (___)_____

Address:_____ Fax: (___)_____

_____ E-mail:_____

STEP 3 *Choose one of these ways to send this request to us. We must get this request by the deadline!*

MAIL: Mail only this page. Follow the steps on the back of this page.

FAX: Fax only this side of this page to 614-728-9574 (ODHS Bureau of State Hearings).

E-MAIL: E-mail to "bsh@odhs.state.oh.us". Please include all the information requested in Steps 1 and 2; and all the information from box at the top of this notice (AG Name, Case Number and Mailing Date).

VISIT OR PHONE YOUR CASEWORKER: It is better to ask for a hearing by using mail, fax or e-mail. You may visit or phone your caseworker. Ask for a "State Hearing." Only you may phone. Take all pages of this notice if you visit your caseworker. Mention this notice if you phone.

KEEP READING >>>

Mailing Steps:
(1) Fold this page only along the dotted lines.
(2) Tape or staple after folding.

JOHN DOE
111 MAIN ST

ANYWHERE OH 99999-9999

NO POSTAGE
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IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO 5249 COLUMBUS OH

POSTAGE WILL BE PAID BY ADDRESSEE

OHIO DEPARTMENT OF HUMAN SERVICES
BUREAU OF STATE HEARINGS
P.O. BOX 182825
COLUMBUS, OHIO 43272-5376

END

PRINT SEQ. 0000005

Client Notice: AE01-X3

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	96134-15
Date Implemented:	8/1/96
Last Date Revised:	July, 2000

Description of Notice:	LEAP auxiliary payment
Assistance Categories:	ADCR, ADCU, ADCI, ADCQ
Hearing Rights:	Yes
Program ID:	GAE501
Transaction ID:	Authorization
Frequency:	Daily
Volume (est. monthly):	
Form Number:	DHS 8500
Notes:	

WDXB 2141

0000006

LUCAS COUNTY DEPT OF HUMAN SERVICES
2460 CHERRY STREET
P.O. BOX 10007
TOLEDO OH 436990007

IMPORTANT NOTICE

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 04/05/1999
From: DEBBIE SOMMER
Phone: (419) 213-8746 Ext:

Worker ID: WDXB48
Case Number: 9999999999
AG Name: JANE DOE

Dear JANE DOE

You will receive an additional OHIO WORKS FIRST (OWF) check, for $200.

The people affected by this action are:
JANE D (ELIGIBLE) JOHN D (ELIGIBLE) JANE D (ELIGIBLE)

Reason:
JANE DOE HAS EARNED THE $200 GRADUATION BONUS. CONGRATULATIONS ON A GREAT JOB!
We based this action on OHIO ADMINISTRATIVE CODE, Rule 5101:1-23-50

RC: 062 ADCR 4 X3

KEEP READING >>>

SEQ# 0003011 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000006
DHS 8500 (Rev. 02/98) 9999999999/ADCR/04 NOTICE TYPE: AE01X3

AG Name:	Case Number:	Mailing Date:
JANE DOE	9999999999	04/05/1999

This "Important 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.

Ask for a State Hearing if you want to appeal.

Ask for a State Hearing if you disagree with what we are doing or think we are making a mistake. At the state hearing, you can explain your reasons. We will explain our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

We must get your request for a State Hearing by the deadline: 07/06/1999.

Please use the next page ("State Hearing Request") to ask for a State Hearing. Save all the other pages of this notice.

Someone else may help you (a lawyer, social worker, friend, relative, etc.). Someone else may request a hearing for you and come to the hearing with you.

You can also get information about free legal services. For free legal help call the Ohio State Legal Services Association at 1-800-589-5888 (a free call).

AG Name:	Case Number:	Mailing Date:
JANE DOE	9999999999	04/05/1999

STATE HEARING REQUEST

Get this to us by the deadline to ask for a State Hearing!

STEP 1 *Check all the boxes that apply, then sign.*

I want a State Hearing. I am most concerned about (optional):

- ☐ Checks or cash assistance (OWF or DA)
- ☐ Food Stamps
- ☐ Medical assistance (Medicaid, Medicare, LIF, Healthy Start, DA Medical, spenddown, nursing homes, QMB, SLMB, etc.)
- ☐ PRC
- ☐ Other (please explain):_____

(examples: child day care, child support, overpayments, etc.)

☐ I also want a County Conference. (A county conference is a meeting with you and staff from our county department of human services.)

My signature:_____ Date:_____ Phone: (___)_____

STEP 2 *You must complete this part if someone else is helping you with your case (a lawyer, social worker, friend, relative, etc.)*

My authorized representative is:

Name:_____Phone: (___)_____

Address:_____ Fax: (___)_____

_____ E-mail:_____

STEP 3 *Choose one of these ways to send this request to us. We must get this request by the deadline!*

MAIL: Mail only this page. Follow the steps on the back of this page.

FAX: Fax only this side of this page to 614-728-9574 (ODHS Bureau of State Hearings).

E-MAIL: E-mail to "bsh@odhs.state.oh.us". Please include all the information requested in Steps 1 and 2; and all the information from box at the top of this notice (AG Name, Case Number and Mailing Date).

VISIT OR PHONE YOUR CASEWORKER: It is better to ask for a hearing by using mail, fax or e-mail. You may visit or phone your caseworker. Ask for a "State Hearing." Only you may phone. Take all pages of this notice if you visit your caseworker. Mention this notice if you phone.

KEEP READING >>>

Mailing Steps:
(1) Fold this page only along the dotted lines.
(2) Tape or staple after folding.

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO 5249 COLUMBUS OH

POSTAGE WILL BE PAID BY ADDRESSEE

OHIO DEPARTMENT OF HUMAN SERVICES
BUREAU OF STATE HEARINGS
P.O. BOX 182825
COLUMBUS, OHIO 43272-5376

END

PRINT SEQ. 0000006

Client Notice: AE01Z1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number: 98068-27

Date Implemented: 09/01/98

Last Date Revised: July, 2000

Description of Notice: The notice is a description of changes to a case with the reason for change.

Assistance Group(s): ADC (OWF)

Hearing Rights: YES

Program ID: GCN093

Transaction ID:

Frequency: Daily

Volume (est. monthly): 200000

Form Number: DHS 8500

Notes:

WBSD 0203

0000670

IMPORTANT NOTICE

FAIRFIELD COUNTY DEPT OF JOBS AND FAMILY SERVICES
P.O. BOX 890

LANCASTER OH 431300000

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 07/10/2000
From: BARBARA D DENNIS
Phone: (614) 653-1701 Ext:

Worker ID: WBSD23
Case Number: 9999999999
AG Name: JANE DOE

Dear JANE DOE

We will STOP your OHIO WORKS FIRST (OWF) on 07/31/2000.

The people affected by this action are:
JANE D (INELIGIBLE) JOHN D (INELIGIBLE) JANE D (INELIGIBLE)

Reason:
FOR A SECOND FAILURE, YOU ARE NOT ELIGIBLE FOR AT LEAST 3 MONTHS. INFORMATION BELOW TELLS HOW YOU FAILED AND WHAT MUST BE DONE TO END THE SANCTION. THE FOLLOWING PEOPLE FAILED TO COMPLY: JOHN DOE
We based this action on OHIO REVISED CODE, Section 5107.14

RC: 631 ADCU 1 T1

JOHN DOE, you failed to comply with the self-sufficiency contract signed 07/07/2000, in the following ways(s):

INDIVIDUAL FAILED OR REFUSED WITHOUT GOOD CAUSE TO PARTICIPATE IN JOB SEARCH/ JOB CLUB ON THE ABOVE DATE(S).
This notice refers to a fail date of 06/30/2000.
In order to end this sanction you must serve the minimum sanction period and do the following:
TO COMPLY, THE SANCTIONED PERSON MUST SIGN A COMPLIANCE FORM AND MAY BE ASSIGNED TO PARTICIPATE FOR UP TO TWO WEEKS IN A WORK ACTIVITY, OR OBTAIN EMPLOYMENT PER COUNTY REQUIREMENTS.

You can ask for a State Hearing and a County Conference if you disagree with our actions. See the end of this notice to learn how to ask for a State Hearing and a County Conference. The number for the OWF ombudsperson in your county is (1-800-450-8845).

KEEP READING >>>

TRANSITIONAL MEDICAID AND CHILD CARE

If you get a job, you may still be eligible for Medicaid benefits even though your income may be too high to continue to receive cash assistance under the Ohio Works First (OWF) program or Medicaid under the Low-Income Families (LIF) program. Listed below are some of the most commonly asked question about Transitional Medicaid Care.

What is Transitional Medicaid?

Transitional Medicaid is a program that provides up to two 6-month periods of Medicaid coverage.

Who is eligible for the first six months?

OWF or LIF assistance groups are eligible for the first 6 months if:

1. Loss of OWF or LIF eligibility was due to income from employment of the parent or specified relative; or due to the expiration of the $250 and one-half disregard; and

2. OWF or LIF was received in 3 out of the last 6 calendar months; and

3. Includes a child under 18 or has not attained 19 years of age and is a full-time student in a secondary school or in the equivalent level of vocational or technical training; and

4. No member of the assistance group has been convicted of OWF or Medicaid fraud within the 6 month period prior to OWF ineligibility.

Who is eligible for the second six months?

OWF or LIF assistance groups are eligible for the second 6 months if:

1. Transitional Medicaid was received during the entire initial 6 month period; and

2. Includes a child under 18 or has not attained 19 years of age and is a full-time student in a secondary school or in the equivalent level of vocational or technical; and

3. Submit quarterly reports; and

4. The average monthly earnings (less child care costs) do not exceed 185% of the federal poverty level; and

5. The parent or specified relative reported earnings for every month covered by the quarterly reports.

KEEP READING >>>

How do I apply for Transitional Medicaid?

When your OWF or LIF assistance is terminated for any reason, your caseworker will review your case record, determine Transitional Medicaid eligibility, and notify you if you are eligible. You will also be notified of your reporting responsibilities.

REPORTING CHANGES

When should I report to my caseworker about a new job or change in my job?

You should report changes to your caseworker as soon as possible, but no later than 10 days after the change has occurred. Changes you must report include if you change jobs, move, someone moves into or out of your household, or if your income or the hours you work change.

HEARING RIGHTS

What if my OWF or LIF was closed for a reason other than employment but I think I am still eligible for Transitional Medicaid?

If you think you may be eligible for Transitional Medicaid, but you have not heard from your caseworker, you should contact the county department of human services to find out if a decision was made about your eligibility for Transitional Medicaid.

What if a family does not agree with a decision made by the County Department of Human Services on whether the family is eligible for Transitional Medicaid?

If a family member does not agree with an action or decision made by the County Department of Human Services, a hearing can be requested. The hearing officer will listen to both sides, then a written decision will be sent to the family and the agency.

KEEP READING >>>

AG Name:	Case Number:	Mailing Date:
JANE DOE	9999999999	07/10/2000

This "Important 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.

Ask for a State Hearing if you want to appeal.

Ask for a State Hearing if you disagree with what we are doing or think we are making a mistake. At the state hearing, you can explain your reasons. We will explain our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

- **The first deadline is 07/25/2000. We will not stop or lower your benefits before your hearing if we get your hearing request by the first deadline.** (However, if you lose the hearing, you may have to repay any benefits you were not eligible to get.)
- The final deadline is 10/10/2000. If we get your hearing request after the first deadline, we will stop or lower your benefits before the hearing. You may still have a hearing but only if we get your request by the final deadline.

Please use the next page ("State Hearing Request") to ask for a State Hearing. Save all the other pages of this notice.

Someone else may help you (a lawyer, social worker, friend, relative, etc.). Someone else may request a hearing for you and come to the hearing with you.

You can also get information about free legal services. For free legal help call the Ohio State Legal Services Association at 1-800-589-5888 (a free call).

AG Name:	Case Number:	Mailing Date:
JANE DOE	9999999999	07/10/2000

STATE HEARING REQUEST

Get this to us by the deadline to ask for a State Hearing!

STEP 1 *Check all the boxes that apply, then sign.*

I want a State Hearing. I am most concerned about (optional):

- ☐ Checks or cash assistance (OWF or DA)
- ☐ Food Stamps
- ☐ Medical assistance (Medicaid, Medicare, LIF, Healthy Start, DA Medical, spenddown, nursing homes, QMB, SLMB, etc.)
- ☐ PRC
- ☐ Other (please explain):_____

(examples: child day care, child support, overpayments, etc.)

☐ I also want a County Conference. (A county conference is a meeting with you and staff from our county department of human services.)

My signature:_____ Date:_____ Phone: (___)_____

STEP 2 *You must complete this part if someone else is helping you with your case (a lawyer, social worker, friend, relative, etc.)*

My authorized representative is:

Name:_____Phone: (___)_____

Address:_____ Fax: (___)_____

_____ E-mail:_____

STEP 3 *Choose one of these ways to send this request to us. We must get this request by the deadline!*

MAIL: Mail only this page. Follow the steps on the back of this page.

FAX: Fax only this side of this page to 614-728-9574 (ODHS Bureau of State Hearings).

E-MAIL: E-mail to "bsh@odhs.state.oh.us". Please include all the information requested in Steps 1 and 2; and all the information from box at the top of this notice (AG Name, Case Number and Mailing Date).

VISIT OR PHONE YOUR CASEWORKER: It is better to ask for a hearing by using mail, fax or e-mail. You may visit or phone your caseworker. Ask for a "State Hearing." Only you may phone. Take all pages of this notice if you visit your caseworker. Mention this notice if you phone.

KEEP READING >>>

Mailing Steps:
(1) Fold this page only along the dotted lines.
(2) Tape or staple after folding.

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO 5249 COLUMBUS OH

POSTAGE WILL BE PAID BY ADDRESSEE

OHIO DEPARTMENT OF HUMAN SERVICES
BUREAU OF STATE HEARINGS
P.O. BOX 182825
COLUMBUS, OHIO 43272-5376

END

PRINT SEQ. 0000670

Client Notice: AE01Z2

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number: 98068-27

Date Implemented: 09/01/98

Last Date Revised: July, 2000

Description of Notice: The notice is a description of changes to a case with the reason for change.

Assistance Group(s): Food Stamps

Hearing Rights: YES

Program ID: GCN093

Transaction ID:

Frequency: Daily

Volume (est. monthly): 200000

Form Number: DHS 8500

Notes:

0002354 WSXS 1025

SANDUSKY COUNTY DEPT OF HUMAN SERVICES
2511 COUNTRYSIDE DRIVE
P.O. BOX 890
FREMONT OH 434200000

IMPORTANT NOTICE

JANE DOE
111 MAIN ST.

ANYWHERE OH 99999-9999

Mailing Date: 09/24/1998
From: SUZANNE COLE
Phone: (419) 334-3891 Ext: 0251

Worker ID: WSXS72
Case Number: 9999999999
AG Name: JANE DOE

Dear JANE DOE

Your FOOD STAMP application dated 08/24/1998 has been DENIED effective 09/23/1998.

The people affected by this action are:
JANE D (INELIGIBLE) JAN D (INELIGIBLE) JOHN D (INELIGIBLE)

Reason: FIRST FAILURE TO COMPLY WITH FOOD STAMP WORK REQUIREMENT
FOR A FIRST FAILURE, YOU ARE NOT ELIGIBLE FOR AT LEAST 1 MONTH. INFORMATION BELOW TELLS HOW YOU FAILED AND WHAT MUST BE DONE TO END THE SANCTION. THE FOLLOWING PEOPLE FAILED TO COMPLY: JANE DOE
We based this action on OHIO ADMINISTRATIVE CODE, Rule 5101:4-3-11

Reason: INCOME IS MORE THAN THE 130% GROSS INCOME STANDARD
We based this action on OHIO ADMINISTRATIVE CODE, Rule 5101:4-4-35

RC: 657 354 FS 1 D1

JANE DOE FAILED OR REFUSED WITHOUT GOOD CAUSE TO REPORT FOR A WORK PROGRAM APPOINTMENT ON 09/08/98 .

In order to demonstrate willingness to comply, after serving the minimum sanction period, the sanctioned person must sign a compliance form and may be assigned to participate for up to two weeks in a work activity before the sanction is ended.

It may be possible to avoid or shorten the sanction period if the sanctioned individual establishes good cause for the failure, can verify an exemption from food stamp work requirements, finds a job comparable to the one he or she quit or increase work efforts to at least thirty hours per week.

The sanctioned individual may reapply at the end of the sanction period.

KEEP READING >>>

AG Name:	Case Number:	Mailing Date:
JANE DOE	9999999999	09/24/1998

This "Important 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.

Ask for a State Hearing if you want to appeal.

Ask for a State Hearing if you disagree with what we are doing or think we are making a mistake. At the state hearing, you can explain your reasons. We will explain our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

We must get your request for a State Hearing by the deadline: 10/10/2000.

Please use the next page ("State Hearing Request") to ask for a State Hearing. Save all the other pages of this notice.

Someone else may help you (a lawyer, social worker, friend, relative, etc.). Someone else may request a hearing for you and come to the hearing with you.

You can also get information about free legal services. For free legal help call the Ohio State Legal Services Association at 1-800-589-5888 (a free call).

AG Name:	Case Number:	Mailing Date:
JANE DOE	9999999999	09/24/1998

STATE HEARING REQUEST

Get this to us by the deadline to ask for a State Hearing!

STEP 1 *Check all the boxes that apply, then sign.*

I want a State Hearing. I am most concerned about (optional):

- ☐ Checks or cash assistance (OWF or DA)
- ☐ Food Stamps
- ☐ Medical assistance (Medicaid, Medicare, LIF, Healthy Start, DA Medical, spenddown, nursing homes, QMB, SLMB, etc.)
- ☐ PRC
- ☐ Other (please explain):_____

(examples: child day care, child support, overpayments, etc.)

☐ I also want a County Conference. (A county conference is a meeting with you and staff from our county department of human services.)

My signature:_____ Date:_____ Phone: (___)_____

STEP 2 *You must complete this part if someone else is helping you with your case (a lawyer, social worker, friend, relative, etc.)*

My authorized representative is:

Name:_____Phone: (___)_____

Address:_____ Fax: (___)_____

_____ E-mail:_____

STEP 3 *Choose one of these ways to send this request to us. We must get this request by the deadline!*

MAIL: Mail only this page. Follow the steps on the back of this page.

FAX: Fax only this side of this page to 614-728-9574 (ODHS Bureau of State Hearings).

E-MAIL: E-mail to "bsh@odhs.state.oh.us". Please include all the information requested in Steps 1 and 2; and all the information from box at the top of this notice (AG Name, Case Number and Mailing Date).

VISIT OR PHONE YOUR CASEWORKER: It is better to ask for a hearing by using mail, fax or e-mail. You may visit or phone your caseworker. Ask for a "State Hearing." Only you may phone. Take all pages of this notice if you visit your caseworker. Mention this notice if you phone.

KEEP READING >>>

Mailing Steps:
(1) Fold this page only along the dotted lines.
(2) Tape or staple after folding.

JANE DOE
111 MAIN ST OH 99999-9999

ANYWHERE OH 99999-9999

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO 5249 COLUMBUS OH

POSTAGE WILL BE PAID BY ADDRESSEE

OHIO DEPARTMENT OF HUMAN SERVICES
BUREAU OF STATE HEARINGS
P.O. BOX 182825
COLUMBUS, OHIO 43272-5376

END

PRINT SEQ. 0000668

Client Notice: AE04-C1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	February, 1998

Description of Notice:	Continuation of benefits with no change (Priority one reason codes)
Assistance Categories:	MA-A, MA-B, MA-D, MA-L
Hearing Rights:	Yes
Program ID:	GAE501
Transaction ID:	Authorization
Frequency:	Daily
Volume (est. monthly):	20
Form Number:	DHS 8503
Notes:	

0000017 WDAB 2202

COLUMBIANA COUNTY DEPT OF HUMAN SERVICES
P.O. BOX 9

LISBON OH 444320000

IMPORTANT NOTICE

JOHN DOE
111 MAIN ST.

ANYWHERE, USA 11111-1111

Mailing Date: 05/12/1998
From: DEBRA A BURCH
Phone: (330) 424-1471 Ext: 0080

Worker ID: WDAB15
Case Number: 1111111111
AG Name: JANE DOE

Dear JANE DOE

Your MEDICAID FOR THE AGED benefits will CONTINUE with no change.

The people affected by this action are:
DOE J (ELIGIBLE)

Reason: INCREASE IN PNA RESULTS IN A DECREASE IN PATIENT LIABILITY
We based this action on OHIO PUBLIC ASSISTANCE MANUAL Section 07542

RC: 130 MA A 1 C1

KEEP READING >>>

SEQ# 0015670 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000017
DHS 8503 (Rev. 02/98) 1111111111/MA A/01 NOTICE TYPE: AE04C1

AG Name:	Case Number:	Mailing Date:
JANE DOE	1111111111	05/12/1998

YOUR RIGHT TO A STATE HEARING

This notice is to tell you about action we are taking on your case. If you do not understand this action, you should contact your caseworker. After talking with your caseworker, it is possible that we will change our decision or that you will agree with the action.

IF YOU DO NOT AGREE WITH THIS ACTION, YOU HAVE A RIGHT TO A STATE HEARING. A state hearing lets you or your representative (lawyer, welfare rights worker, friend or relative) give your reasons against the action. We will also attend the hearing to present our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

If you want a hearing we must receive your hearing request within 90 days of the mailing date on this notice.

If someone else makes a written hearing request for you, it must include a written statement, signed by you, telling us that person is your representative. Only you can make a request by telephone.

If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association, toll free at 1-(800)-589-5888, for the local number.

If you want a state hearing, check the appropriate box below, sign and date this form and send ALL PAGES to the Ohio Department of Human Services, State Hearings, 30 East Broad Street, 31st floor, Columbus, Ohio 43266-0423.

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

☐ I want a state hearing only.

I want a hearing.

SIGNATURE	DATE	TELEPHONE NUMBER

END

Client Notice: AE04-I1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	February, 1998

Description of Notice:	Increase in benefit (Priority one reason codes)
Assistance Categories:	ADC, GA, FS, MA (OSS)
Hearing Rights:	Yes
Program ID:	GAE501
Transaction ID:	Authorization
Frequency:	Daily
Volume (est. monthly):	90
Form Number:	DHS 8503

Notes:

0000021 WSAB 1014

CLERMONT COUNTY DEPT OF HUMAN SERVICES
2400 CLERMONT CENTER DRIVE
SUITE 106A
BATAVIA OH 451030000

IMPORTANT NOTICE

JANE DOE
111 MAIN ST.

ANYWHERE, USA 11111-1111

Mailing Date: 05/13/1998
From: S BUCZAK
Phone: (513) 732-7111 Ext:

Worker ID: WSAB13
Case Number: 1111111111
AG Name: JANE DOE

Dear JANE DOE

Your FOOD STAMP benefits will be INCREASED from $311.00 to $330.00 effective 06/01/1998.

The people affected by this action are:
JANE D (ELIGIBLE) JANE D (ELIGIBLE) JANE D (ELIGIBLE) JANE D (ELIGIBLE) JOHN D (INELIGIBLE)

Reason: ALL ELIGIBILITY REQUIREMENTS HAVE BEEN MET
We based this action on OHIO FOOD STAMP CERTIFICATION HANDBOOK Section 05140

RC: 091 FS 1 I1

KEEP READING >>>

SEQ# 0016422 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000021
DHS 8503 (Rev. 02/98) 1111111111/FS /01 NOTICE TYPE: AE04I1

AG Name:	Case Number:	Mailing Date:
JANE DOE	1111111111	05/13/1998

YOUR RIGHT TO A STATE HEARING

This notice is to tell you about action we are taking on your case. If you do not understand this action, you should contact your caseworker. After talking with your caseworker, it is possible that we will change our decision or that you will agree with the action.

IF YOU DO NOT AGREE WITH THIS ACTION, YOU HAVE A RIGHT TO A STATE HEARING. A state hearing lets you or your representative (lawyer, welfare rights worker, friend or relative) give your reasons against the action. We will also attend the hearing to present our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

If you want a hearing we must receive your hearing request within 90 days of the mailing date on this notice.

If someone else makes a written hearing request for you, it must include a written statement, signed by you, telling us that person is your representative. Only you can make a request by telephone.

If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association, toll free at 1-(800)-589-5888, for the local number.

If you want a state hearing, check the appropriate box below, sign and date this form and send ALL PAGES to the Ohio Department of Human Services, State Hearings, 30 East Broad Street, 31st floor, Columbus, Ohio 43266-0423.

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

☐ I want a state hearing only.

I want a hearing.

SIGNATURE	DATE	TELEPHONE NUMBER

END

Client Notice: AE04-I2

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	February, 1998

Description of Notice:	Decrease of Medicaid spenddown amount (Priority one reason codes)
Assistance Categories:	MA-A, MA-B, MA-D)
Hearing Rights:	Yes
Program ID:	GAE501
Transaction ID:	Authorization
Frequency:	Daily
Volume (est. monthly):	5
Form Number:	DHS 8503
Notes:	

0000001 WSSW 2434

HAMILTON COUNTY DEPT OF HUMAN SERVICES
222 E. CENTRAL PARKWAY

CINCINNATI OH 452020000

IMPORTANT NOTICE

JANE DOE
111 MAIN ST.

ANYWHERE, USA 11111-1111

Mailing Date: 08/08/1996
From: MS. S WAKEFIELD
Phone: (513) 946-1195 Ext:

Worker ID: WSSW31
Case Number: 1111111111
AG Name: JANE DOE

Dear JANE DOE

Your TRANSITIONAL MEDICAID Spenddown liability will be DECREASED from $295.00 to $245.00 effective 09/01/1996.

The people affected by this action are:
DAEZA M (ELIGIBLE) JANET M (ELIGIBLE) PIERR T (ELIGIBLE) CELES T (INELIGIBLE) JARRE T (ELIGIBLE)

Reason: FAILURE TO MEET SPENDDOWN LIABILITY

We based this action on OHIO PUBLIC ASSISTANCE MANUAL Section 07467

RC: 403 MA Y 1 I2

KEEP READING >>>

SEQ# 0005200 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000001
DHS 8503 (Rev. 02/98) 1111111111/MA Y/01 NOTICE TYPE: AE04I2

AG Name:	Case Number:	Mailing Date:
JANE DOE	1111111111	08/08/1996

YOUR RIGHT TO A STATE HEARING

This notice is to tell you about action we are taking on your case. If you do not understand this action, you should contact your caseworker. After talking with your caseworker, it is possible that we will change our decision or that you will agree with the action.

IF YOU DO NOT AGREE WITH THIS ACTION, YOU HAVE A RIGHT TO A STATE HEARING. A state hearing lets you or your representative (lawyer, welfare rights worker, friend or relative) give your reasons against the action. We will also attend the hearing to present our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

If you want a hearing we must receive your hearing request within 90 days of the mailing date on this notice.

If someone else makes a written hearing request for you, it must include a written statement, signed by you, telling us that person is your representative. Only you can make a request by telephone.

If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association, toll free at 1-(800)-589-5888, for the local number.

If you want a state hearing, check the appropriate box below, sign and date this form and send ALL PAGES to the Ohio Department of Human Services, State Hearings, 30 East Broad Street, 31st floor, Columbus, Ohio 43266-0423.

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

☐ I want a state hearing only.

I want a hearing.

SIGNATURE	DATE	TELEPHONE NUMBER

END

Client Notice: AE04-I3

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	February, 1998

Description of Notice:	Decrease in Medicaid nursing home patient liability (Priority one reason codes)
Assistance Categories:	MA-A, MA-B, MA-D
Hearing Rights:	Yes
Program ID:	GAE501
Transaction ID:	Authorization
Frequency:	Daily
Volume (est. monthly):	100
Form Number:	DHS 8503

Notes:

0000002 WSSW 2434

HAMILTON COUNTY DEPT OF HUMAN SERVICES
222 E. CENTRAL PARKWAY

CINCINNATI OH 452020000

IMPORTANT NOTICE

JANE DOE
111 MAIN ST.

ANYWHERE, USA 11111-1111

Mailing Date: 08/08/1996
From: MS. S WAKEFIELD
Phone: (513) 946-1195 Ext:

Worker ID: WSSW31
Case Number: 1111111111
AG Name: JANE DOE

Dear JANE DOE

Your TRANSITIONAL MEDICAID patient liability will be DECREASED from $245.00 to $295.00 effective 09/01/1996.

The people affected by this action are:
DAEZA M (ELIGIBLE) JANET M (ELIGIBLE) PIERR T (ELIGIBLE) CELES T (INELIGIBLE) JARRE T (ELIGIBLE)

Reason: FAILURE TO MEET SPENDDOWN LIABILITY
We based this action on OHIO PUBLIC ASSISTANCE MANUAL Section 07467

RC: 403 MA Y 1 I3

KEEP READING >>>

SEQ# 0005300 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000002
DHS 8503 (Rev. 02/98) 1111111111/MA Y/01 NOTICE TYPE: AE04I3

AG Name:	Case Number:	Mailing Date:
JANE DOE	1111111111	08/08/1996

YOUR RIGHT TO A STATE HEARING

This notice is to tell you about action we are taking on your case. If you do not understand this action, you should contact your caseworker. After talking with your caseworker, it is possible that we will change our decision or that you will agree with the action.

IF YOU DO NOT AGREE WITH THIS ACTION, YOU HAVE A RIGHT TO A STATE HEARING. A state hearing lets you or your representative (lawyer, welfare rights worker, friend or relative) give your reasons against the action. We will also attend the hearing to present our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

If you want a hearing we must receive your hearing request within 90 days of the mailing date on this notice.

If someone else makes a written hearing request for you, it must include a written statement, signed by you, telling us that person is your representative. Only you can make a request by telephone.

If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association, toll free at 1-(800)-589-5888, for the local number.

If you want a state hearing, check the appropriate box below, sign and date this form and send ALL PAGES to the Ohio Department of Human Services, State Hearings, 30 East Broad Street, 31st floor, Columbus, Ohio 43266-0423.

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

☐ I want a state hearing only.

I want a hearing.

SIGNATURE	DATE	TELEPHONE NUMBER

END

Client Notice: AE04-M1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	February, 1998

Description of Notice:	Notice of no change in benefits although there has been a change in eligible individuals (Priority one reason codes)
Assistance Categories:	ADC, GA, FS, MA Y,C,H,P,Q,S,T,V,W,G,X,Z,MAYP,CP,HP,PP,SP,TP,VP, WP,XP,ZP,GP
Hearing Rights:	Yes
Program ID:	GAE501
Transaction ID:	Authorization
Frequency:	Daily
Volume (est. monthly):	70
Form Number:	DHS 8503
Notes:	

0000022 WLAE 1016

MEDINA COUNTY DEPT OF HUMAN SERVICES
980 N. COURT ST.
P.O. BOX 1239
MEDINA OH 442580000

IMPORTANT NOTICE

JANE DOE
111 MAIN ST.

ANYWHERE, USA 11111-1111

Mailing Date: 05/08/1998
From: LISA EARLE
Phone: (330) 722-9283 Ext: 0236

Worker ID: WLAE52
Case Number: 1111111111
AG Name: JANE DOE

Dear JANE DOE

The number of eligible TRANSITIONAL MEDICAID individuals has changed. TRANSITIONAL MEDICAID benefits for eligible individuals will CONTINUE with no change.

The people affected by this action are:
JANE D (ELIGIBLE) JANE D (ELIGIBLE) JOHN D (ELIGIBLE)

Reason: ELIGIBLE FOR TWELVE-MONTH EXTENDED MEDICAID
We based this action on OHIO PUBLIC ASSISTANCE MANUAL Section 00000

Reason: ALL ELIGIBILITY REQUIREMENTS HAVE BEEN MET
We based this action on OHIO PUBLIC ASSISTANCE MANUAL Section 01020

Reason: 12 MONTH TRANSITIONAL BENEFITS HAVE ENDED
We based this action on OHIO PUBLIC ASSISTANCE MANUAL Section 00000

RC: 042 091 496 MA Y 1 M1

KEEP READING >>>

SEQ# 0014743 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000022
DHS 8503 (Rev. 02/98) 1111111111/MA Y/01 NOTICE TYPE: AE04M1

AG Name:	Case Number:	Mailing Date:
JANE DOE	1111111111	05/08/1998

YOUR RIGHT TO A STATE HEARING

This notice is to tell you about action we are taking on your case. If you do not understand this action, you should contact your caseworker. After talking with your caseworker, it is possible that we will change our decision or that you will agree with the action.

IF YOU DO NOT AGREE WITH THIS ACTION, YOU HAVE A RIGHT TO A STATE HEARING. A state hearing lets you or your representative (lawyer, welfare rights worker, friend or relative) give your reasons against the action. We will also attend the hearing to present our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

If you want a hearing we must receive your hearing request within 90 days of the mailing date on this notice.

If someone else makes a written hearing request for you, it must include a written statement, signed by you, telling us that person is your representative. Only you can make a request by telephone.

If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association, toll free at 1-(800)-589-5888, for the local number.

If you want a state hearing, check the appropriate box below, sign and date this form and send ALL PAGES to the Ohio Department of Human Services, State Hearings, 30 East Broad Street, 31st floor, Columbus, Ohio 43266-0423.

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

☐ I want a state hearing only.

I want a hearing.

SIGNATURE	DATE	TELEPHONE NUMBER

END

Client Notice: AE04-R1

A client notice name is composed of the **Notice Type**, which is four characters, and a n**Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	February, 1998

Description of Notice:	Decrease in benefits (Priority one reason codes)
Assistance Categories:	All
Hearing Rights:	Yes
Program ID:	GAE501
Transaction ID:	Authorization
Frequency:	Daily
Volume (est. monthly):	700
Form Number:	DHS 8503
Notes:	This notice is sent on or before the effective date of the action rather than 15 days in advance.

0000001 WSKI 2943

FRANKLIN CO. JO COUNTY DEPT OF HUMAN SERVICES
1055 MT. VERNON AVE

COLUMBUS OH 432030000

IMPORTANT NOTICE

JANE DOE
111 MAIN ST

ANYWHERE, OH 99999-9999

Mailing Date: 03/11/1999
From: SHARI K IRVING
Phone: (614) 251-4953 Ext:

Worker ID: WSKI25
Case Number: 9999999999
AG Name: JANE DOE

Dear JANE DOE

We will LOWER your FOOD STAMP from $665 to $571 each month starting 04/01/1999.

The people affected by this action are:
JANE D (ELIGIBLE) JOHN D (ELIGIBLE) JANE D (ELIGIBLE) JOHN D (ELIGIBLE)
JANE D (ELIGIBLE) JOHN D (ELIGIBLE) JANE D (ELIGIBLE) JOHN D (ELIGIBLE)

Reason:
JANE DOE IS BEING REMOVED FROM THE ASSISTANCE GROUP AT YOUR WRITTEN REQUEST.
We based this action on OHIO ADMINISTRATIVE CODE, Rule 5101:4-3-05

Reason: ALL ELIGIBILITY REQUIREMENTS HAVE BEEN MET
We based this action on OHIO ADMINISTRATIVE CODE, Rule 5101:4-5-07

RC: 343 091 FS 1 R1

KEEP READING >>>

SEQ# 0014899 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000001
DHS 8503 (Rev. 02/98) 9999999999/FS /01 NOTICE TYPE: AE04R1

AG Name:	Case Number:	Mailing Date:
JANE DOE	9999999999	03/11/1999

YOUR RIGHT TO A STATE HEARING

This notice is to tell you about action we are taking on your case. If you do not understand this action, you should contact your caseworker. After talking with your caseworker, it is possible that we will change our decision or that you will agree with the action.

IF YOU DO NOT AGREE WITH THIS ACTION, YOU HAVE A RIGHT TO A STATE HEARING. A state hearing lets you or your representative (lawyer, welfare rights worker, friend or relative) give your reasons against the action. We will also attend the hearing to present our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

If you want a hearing we must receive your hearing request within 90 days of the mailing date on this notice.

If we receive your request by 3/26/1999, the action will not be taken until the state hearing is decided. If you lose your hearing, you may have to pay back benefits that you were not eligible to receive.

If someone else makes a written hearing request for you, it must include a written statement, signed by you, telling us that person is your representative. Only you can make a request by telephone.

If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association, toll free at 1-(800)-589-5888, for the local number.

If you want a state hearing, check the appropriate box below, sign and date this form and send ALL PAGES to the Ohio Department of Human Services, State Hearings, 30 East Broad Street, 31st floor, Columbus, Ohio 43266-0423.

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

☐ I want a state hearing only.

WAIVER OF CONTINUING BENEFITS (FOOD STAMPS ONLY)

☐ I agree to let the county department of human services go ahead with the food stamp action(s) now, even though I have requested a hearing.

I want a hearing.

SIGNATURE	DATE	TELEPHONE NUMBER

END

Client Notice: AE04-R2

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	December, 1996

Description of Notice:	Increase in Medicaid spenddown liability (Priority one reason codes)
Assistance Categories:	MA only
Hearing Rights:	Yes
Program ID:	GAE501
Transaction ID:	Authorization
Frequency:	Daily
Volume (est. monthly):	58
Form Number:	DHS 8503
Notes:	This notice is sent on or before the effective date of the action rather than 15 days in advance.

0000001 WSCC 1202

CLARK COUNTY DEPT OF HUMAN SERVICES
1345 LAGONDA AVE

SPRINGFIELD OH 455030000

IMPORTANT NOTICE

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 08/08/1996
From: SANDRA A CURTIS
Phone: (513) 327-1932 Ext:

Worker ID: WSCC12
Case Number: 9999999999
AG Name: JANE DOE

Dear JANE DOE

We will RAISE your FOOD STAMP spenddown from $171 to $107 each month starting 09/01/1996.

The people affected by this action are:
JANE D (INELIGIBLE) JOHN D (ELIGIBLE) JANE D (ELIGIBLE)

Reason: DEPENDENT CARE COSTS HAVE DECREASED
We based this action on OHIO REVISED CODE, Section

RC: 397 FS 1 R2

KEEP READING >>>

SEQ# 0005600 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000001
DHS 8503 (Rev. 02/98) 9999999999/FS /01 NOTICE TYPE: AE04R2

AG Name:	Case Number:	Mailing Date:
JANE DOE	9999999999	08/08/1996

YOUR RIGHT TO A STATE HEARING

This notice is to tell you about action we are taking on your case. If you do not understand this action, you should contact your caseworker. After talking with your caseworker, it is possible that we will change our decision or that you will agree with the action.

IF YOU DO NOT AGREE WITH THIS ACTION, YOU HAVE A RIGHT TO A STATE HEARING. A state hearing lets you or your representative (lawyer, welfare rights worker, friend or relative) give your reasons against the action. We will also attend the hearing to present our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

If you want a hearing we must receive your hearing request within 90 days of the mailing date on this notice.

If we receive your request by 8/23/1996, the action will not be taken until the state hearing is decided. If you lose your hearing, you may have to pay back benefits that you were not eligible to receive.

If someone else makes a written hearing request for you, it must include a written statement, signed by you, telling us that person is your representative. Only you can make a request by telephone.

If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association, toll free at 1-(800)-589-5888, for the local number.

If you want a state hearing, check the appropriate box below, sign and date this form and send ALL PAGES to the Ohio Department of Human Services, State Hearings, 30 East Broad Street, 31st floor, Columbus, Ohio 43266-0423.

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

☐ I want a state hearing only.

WAIVER OF CONTINUING BENEFITS (FOOD STAMPS ONLY)

☐ I agree to let the county department of human services go ahead with the food stamp action(s) now, even though I have requested a hearing.

I want a hearing.

SIGNATURE	DATE	TELEPHONE NUMBER

END

Client Notice: AE04-R3

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	February, 1998

Description of Notice:	Increase in Medicaid Nursing Home patient liability (Priority one reason codes)
Assistance Categories:	MA-A, MA-B, MA-D
Hearing Rights:	Yes
Program ID:	GAE501
Transaction ID:	Authorization
Frequency:	Daily
Volume (est. monthly):	1200
Form Number:	DHS 8503
Notes:	This notice is sent on or before the effective date of the action rather than 15 days in advance.

0000003 WSCC 1202

CLARK COUNTY DEPT OF HUMAN SERVICES
1345 LAGONDA AVE

SPRINGFIELD OH 455030000

IMPORTANT NOTICE

JANE DOE
111 MAIN ST.

ANYWHERE USA 11111-1111

Mailing Date: 08/08/1996
From: SANDRA A CURTIS
Phone: (513) 327-1932 Ext:

Worker ID: WSCC12
Case Number: 1111111111
AG Name: JANE DOE

Dear JANE DOE

Your patient liability will be INCREASED from $107.00 to $171.00 effective 09/01/1996.

The people affected by this action are:
CARLA S (INELIGIBLE) GREGO J (ELIGIBLE) JASMI S (ELIGIBLE)

Reason: DEPENDENT CARE COSTS HAVE DECREASED
We based this action on OHIO PUBLIC ASSISTANCE MANUAL Section

RC: 397 ma y 1 R3

KEEP READING >>>

SEQ# 0005700 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000003
DHS 8503 (Rev. 02/98) 1111111111/ma y/01 NOTICE TYPE: AE04R3

AG Name:	Case Number:	Mailing Date:
JANE DOE	1111111111	08/08/1996

YOUR RIGHT TO A STATE HEARING

This notice is to tell you about action we are taking on your case. If you do not understand this action, you should contact your caseworker. After talking with your caseworker, it is possible that we will change our decision or that you will agree with the action.

IF YOU DO NOT AGREE WITH THIS ACTION, YOU HAVE A RIGHT TO A STATE HEARING. A state hearing lets you or your representative (lawyer, welfare rights worker, friend or relative) give your reasons against the action. We will also attend the hearing to present our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

If you want a hearing we must receive your hearing request within 90 days of the mailing date on this notice.

If we receive your request by 8/23/1996, the action will not be taken until the state hearing is decided. If you lose your hearing, you may have to pay back benefits that you were not eligible to receive.

If someone else makes a written hearing request for you, it must include a written statement, signed by you, telling us that person is your representative. Only you can make a request by telephone.

If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association, toll free at 1-(800)-589-5888, for the local number.

If you want a state hearing, check the appropriate box below, sign and date this form and send ALL PAGES to the Ohio Department of Human Services, State Hearings, 30 East Broad Street, 31st floor, Columbus, Ohio 43266-0423.

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

☐ I want a state hearing only.

I want a hearing.

SIGNATURE	DATE	TELEPHONE NUMBER

END

Client Notice AE04-T1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	February, 1998

Description of Notice:	Termination of benefit (Priority one reason codes)
Assistance Categories:	All AG's except MA-A, MA-B & MA-D;MA C, MA-CP; With spenddown not > 0
Hearing Rights:	Yes
Program ID:	GAE501
Transaction ID:	Authorization
Frequency:	Daily
Volume (est. monthly):	13000
Form Number:	DHS 8503

Notes:

0000001 WMEM 0024

FAIRFIELD COUNTY DEPT OF HUMAN SERVICES
P.O. BOX 890

LANCASTER OH 431300000

IMPORTANT NOTICE

JANE DOE
111 MAIN ST
NONAME MANOR
ANYWHERE, OH 99999-9999

Mailing Date: 03/11/1999
From: MARTY E MOORE
Phone: (614) 653-1701 Ext:

Worker ID: WMEM23
Case Number: 9999999999
AG Name: JANE ODE

Dear JANE DOE

We will STOP your MEDICAID FOR THE AGED on 03/31/1999.

The people affected by this action are:
JANE D (INELIGIBLE)

Reason:
JANE DOE IS DECEASED .
We based this action on OHIO ADMINISTRATIVE CODE, Rule 07403

RC: 372 MA A 1 T1

KEEP READING >>>

SEQ# 0014833 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000001
DHS 8503 (Rev. 02/98) 9999999999/MA A/01 NOTICE TYPE: AE04T1

AG Name:	Case Number:	Mailing Date:
JANE DOE	9999999999	03/11/1999

YOUR RIGHT TO A STATE HEARING

This notice is to tell you about action we are taking on your case. If you do not understand this action, you should contact your caseworker. After talking with your caseworker, it is possible that we will change our decision or that you will agree with the action.

IF YOU DO NOT AGREE WITH THIS ACTION, YOU HAVE A RIGHT TO A STATE HEARING. A state hearing lets you or your representative (lawyer, welfare rights worker, friend or relative) give your reasons against the action. We will also attend the hearing to present our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

If you want a hearing we must receive your hearing request within 90 days of the mailing date on this notice.

If we receive your request by 3/26/1999, the action will not be taken until the state hearing is decided. If you lose your hearing, you may have to pay back benefits that you were not eligible to receive.

If someone else makes a written hearing request for you, it must include a written statement, signed by you, telling us that person is your representative. Only you can make a request by telephone.

If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association, toll free at 1-(800)-589-5888, for the local number.

If you want a state hearing, check the appropriate box below, sign and date this form and send ALL PAGES to the Ohio Department of Human Services, State Hearings, 30 East Broad Street, 31st floor, Columbus, Ohio 43266-0423.

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

☐ I want a state hearing only.

I want a hearing.

SIGNATURE	DATE	TELEPHONE NUMBER

END

Client Notice: AE04-T2

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	February, 1998

Description of Notice:	Termination of Medicaid, with explanation of possible spenddown eligibility (Priority one reason codes)
Assistance Categories:	MA-A, MA-B, MA-D, MA-L with spenddown amount > 0
Hearing Rights:	Yes
Program ID:	GAE501
Transaction ID:	Authorization
Frequency:	Daily
Volume (est. monthly):	200
Form Number:	DHS 8503
Notes:	

0000030 WTXM 1013

ERIE COUNTY DEPT OF HUMAN SERVICES
221 W. PARISH ST.

SANDUSKY OH 448700000

IMPORTANT NOTICE

JOHNDOE
111 MAIN SST.

ANYWHERE, USA

Mailing Date: 05/13/1998
From: TAMMY MARCUM
Phone: (419) 624-6455 Ext:

Worker ID: WTXM22
Case Number: 1111111111
AG Name: JOHN DOE

Dear JOHNDOE

Your MEDICAID FOR THE DISABLED benefits will be TERMINATED effective 05/31/1998 unless you continue to be eligible for a Medicaid card as a Spenddown recipient. If you can prove to the county department of human services that you have $1,423.00 of medical expenses each month, your medical card will be released to you.

The people affected by this action are:
JOHN D (INELIGIBLE)

Reason: RESIDENT OF JAIL/PRISON
JOHN DOE IS INCARCERATED.
We based this action on OHIO PUBLIC ASSISTANCE MANUAL Section 01425

RC: 468 MA D 1 T2

KEEP READING >>>

SEQ# 0016419 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000030
DHS 8503 (Rev. 02/98) 1111111111/MA D/01 NOTICE TYPE: AE04T2

AG Name:	Case Number:	Mailing Date:
JOHN DOE	1111111111	05/13/1998

YOUR RIGHT TO A STATE HEARING

This notice is to tell you about action we are taking on your case. If you do not understand this action, you should contact your caseworker. After talking with your caseworker, it is possible that we will change our decision or that you will agree with the action.

IF YOU DO NOT AGREE WITH THIS ACTION, YOU HAVE A RIGHT TO A STATE HEARING. A state hearing lets you or your representative (lawyer, welfare rights worker, friend or relative) give your reasons against the action. We will also attend the hearing to present our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

If you want a hearing we must receive your hearing request within 90 days of the mailing date on this notice.

If we receive your request by 5/28/1998, the action will not be taken until the state hearing is decided. If you lose your hearing, you may have to pay back benefits that you were not eligible to receive.

If someone else makes a written hearing request for you, it must include a written statement, signed by you, telling us that person is your representative. Only you can make a request by telephone.

If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association, toll free at 1-(800)-589-5888, for the local number.

If you want a state hearing, check the appropriate box below, sign and date this form and send ALL PAGES to the Ohio Department of Human Services, State Hearings, 30 East Broad Street, 31st floor, Columbus, Ohio 43266-0423.

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

☐ I want a state hearing only.

I want a hearing.

SIGNATURE	DATE	TELEPHONE NUMBER

END

Client Notice: AE04-X2

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	December, 1996

Description of Notice:	Notice of auxilliary check to correct underpayment (Priority one reason codes)
Assistance Categories:	
Hearing Rights:	Yes
Program ID:	GAE501
Transaction ID:	Authorization
Frequency:	Daily
Volume (est. monthly):	
Form Number:	DHS 8503
Notes:	GA used to be an AG. GA was discontinued 7/31/95.

IMPORTANT NOTICE

FAIRFIELD COUNTY DEPT OF HUMAN SERVICES
P.O. BOX 540

KINSINGTY OH 431300000

As of 06/01/1998 you have used 04 months of your initial 36 months of Ohio Works First benefit eligibility. If you continue to be eligible, you have 32 months remaining. After you have used up your 36 months, you might be eligible for additional months. See your caseworker.

JOHN DOE
PO BOX 111

ANYWHERE, USA 11111-1111

Mailing Date: 06/02/1998
From: TERRANCE O BOSTONIAN
Phone: (301) 777-9311 Ext: 1111

Worker ID: WFAX00
Case Number: 1110000000
AG Name: JOHN DOE

Dear JOHN DOE

From 06/01/1998 through 07/01/1998 your assistance group received $23.00 less in MEDICAID FOR THE DISABLED benefits than you should have received. You will receive an additional $23.00 in MEDICAID FOR THE DISABLED benefits for that period.

The following individuals are members of this assistance group:
JANE D (INELIGIBLE)

REASON: TERMINATION OF ASSISTANCE GROUP REQUESTED IN WRITING
JANE DOE IS BEING REMOVED FROM THE ASSISTANCE GROUP AT YOUR WRITTEN REQUEST JANE DOE IS BEING REMOVED FROM THE ASSISTANCE GROUP AT YOUR WRITTEN REQUEST.
The regulation supporting this action is contained in OHIO PUBLIC ASSISTANCE MANUAL Section 01010

RC: 343 MA D 1 X2

KEEP READING >>>

AG Name:	Case Number:	Mailing Date:
JOHN DOE	1110000000	06/02/1998

YOUR RIGHT TO A STATE HEARING

This notice is to tell you about action we are taking on your case. If you do not understand this action, you should contact your caseworker. After talking with your caseworker, it is possible that we will change our decision or that you will agree with the action.

IF YOU DO NOT AGREE WITH THIS ACTION, YOU HAVE A RIGHT TO A STATE HEARING. A state hearing lets you or your representative (lawyer, welfare rights worker, friend or relative) give your reasons against the action. We will also attend the hearing to present our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

If you want a hearing we must receive your hearing request within 90 days of the mailing date on this notice.

If someone else makes a written hearing request for you, it must include a written statement, signed by you, telling us that person is your representative. Only you can make a request by telephone.

If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association, toll free at 1-(800)-589-5888, for the local number.

If you want a state hearing, check the appropriate box below, sign and date this form and send ALL PAGES to the Ohio Department of Human Services, State Hearings, 30 East Broad Street, 31st floor, Columbus, Ohio 43266-0423.

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

☐ I want a state hearing only.

I want a hearing.

SIGNATURE	DATE	TELEPHONE NUMBER

END

Client Notice: AE05-F1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	December, 1997

Description of Notice:	Notice of inter-county transfer
Assistance Categories:	All
Hearing Rights:	No
Program ID:	GAE128
Transaction ID:	AEICI, AEOTR
Frequency:	Daily
Volume (est. monthly):	3300
Form Number:	DHS 8504

Notes:

0000053 WEAS 0025

FAIRFIELD COUNTY DEPT OF HUMAN SERVICES
P.O. BOX 890

LANCASTER OH 431300000

IMPORTANT NOTICE

JANE DOE
111 MAIN ST.

ANYWHERE, USA 11111-1111

Mailing Date: 05/13/1998
From: ELIZABETH A SNELL
Phone: (513) 732-7129 Ext:

Worker ID: WEAS13
Case Number: 1111111111
AG Name: JANE DOE

Dear JANE DOE

You have reported that you have moved from CLERMONT to FAIRFIELD County. In order to determine your eligibility for continuing benefits, you must contact the county department of human services located at:

FAIRFIELD COUNTY DEPARTMENT OF HUMAN SERVICES
P.O. BOX 890

LANCASTER OH 431300000

YOU MUST CONTACT THE COUNTY DEPARTMENT OF HUMAN SERVICES BY 05/26/1998.

If you do not understand or have any questions about this notice, please contact the worker named above.

END

SEQ# 0021534 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000053
ODS 8504 (Rev. 12/97) 1111111111/FS /01 NOTICE TYPE: AE05F1

Client Notice: AE07-TM

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	December, 1997

Description of Notice:	Explanation of transitional ADC-related Medicaid
Assistance Categories:	MA-Y
Hearing Rights:	No
Program ID:	GAE501
Transaction ID:	Authorization
Frequency:	Daily
Volume (est. monthly):	4440
Form Number:	DHS 8535

Notes:

0000067 WKRL 0064

FAIRFIELD COUNTY DEPT OF HUMAN SERVICES
P.O. BOX 890

LANCASTER OH 431300000

IMPORTANT NOTICE

JANE DOE
111 MAIN ST.

ANYWHERE, USA 11111-1111

Mailing Date: 05/13/1998
From: KATHY R LAWSON
Phone: (614) 653-1701 Ext: 6720

Worker ID: WKRL23
Case Number: 1111111111
AG Name: JANE DOE

Dear JANE DOE

IMPORTANT INFORMATION CONCERNING TRANSITIONAL MEDICAID

You and your assistance group have been found eligible for Transitional Medicaid. This means you will receive Medicaid care, just like you received while on OWF. It will cover the same items that your old card covered.

This Medicaid program will last up to 12 months from the first month you were no longer eligible for OWF.

To continue to receive your Medicaid card for the entire 12 month period, there are a few things that must happen.

1) There must continue to be a child in your home.

2) You must turn in a report on your assistance group's earnings and child care expenses every four months. (This is explained below.)

3) Your family's earnings (minus child care costs) need to be less than 185% of the federal poverty level.

4) If the caretaker relative is the member who is employed, he or she needs to continue working each month.

KEEP READING >>>

SEQ# 0021630 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000067
ODS 8535 (Rev. 12/97) 1111111111/MA Y/01 NOTICE TYPE: AE07TM

REPORTING REQUIREMENTS

A report form will be sent to your address every three months for you to fill out. There are only a few questions. They ask about your household's wages and child care costs for each of the past three months.

You will need to complete the report and send it to your county department of human services. You must attach pay stubs received for the last three months. It is important that your family save their pay stubs so you can send them in for proof of your household's earnings. The report is due at the human services office no later than the 5th of the following month.

If your household fails to turn in a report by the 5th, you will be sent a notice to remind you that one is past due. If you choose to not submit a report, your household will no longer be eligible for Transitional Medicaid Assistance.

END

Client Notice: AE09-M1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	December, 1997

Description of Notice:	Notice of excess spousal resources.
Assistance Categories:	MA-A, MA-B, MA-D
Hearing Rights:	No
Program ID:	GAE501
Transaction ID:	Authorization
Frequency:	Daily
Volume (est. monthly):	100
Form Number:	DHS 8541
Notes:	

0000076 WRAH 1882

HAMILTON COUNTY DEPT OF HUMAN SERVICES
222 E. CENTRAL PARKWAY

CINCINNATI OH 452020000

IMPORTANT NOTICE

JOHN DOE
JOHN DOE
111 MAIN ST.
ANYWHERE, USA 11111-1111

Mailing Date: 05/13/1998
From: MS. R HUNTER-MILLER
Phone: (513) 558-1914 Ext:

Worker ID: WRAH31
Case Number: 1111111111
AG Name: JANE DOE

Dear JANE DOE

We have determined that you have resources in your name in the amount of $2.00 which are in excess of the amount allowed for your spouse to be eligible for Medicaid.

Ohio laws require that a husband and wife support each other. Because of these laws and the rules that govern Medicaid eligibility, you must share your resources with your spouse. If you refuse to share your resources with your spouse, the Ohio Department of Human Services and the Attorney General's office will take legal action against you for the costs of the medical services paid by Medicaid for your spouse. Ohio Revised Code Section 5105.58 is the law that allows the Ohio Department of Human Services to collect this money.

If you are willing to share the above amount of your resources with your spouse, check the following box, sign your name and date, and send this letter back to the county department of human services within seven calendar days of the mailing date of this notice.

☐ I AGREE TO SHARE $_____ OF MY RESOURCES WITH MY SPOUSE. I UNDERSTAND THAT MY SPOUSE WILL NOT RECEIVE MEDICAID UNTIL THE AMOUNT OF MY RESOURCES THAT IS DETERMINED TO BE MY SPOUSE'S SHARE FALLS BELOW THE MEDICAID RESOURCE LIMIT FOR AN INDIVIDUAL. I UNDERSTAND THAT LEGAL ACTION AGAINST ME WILL NOT OCCUR.

_____ (Signature)

_____ (Date)

KEEP READING >>>

If this letter is not returned to the county department of human services by 05/20/1998 with the block above checked, signed and dated the Ohio Department of Human Services will begin to take legal action.

If you do not understand or have any questions about this notice, please contact the worker named above.

END

Client Notice: AE10-M1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	December, 1996

Description of Notice:	Expedited Medicaid Approval Notice
Assistance Categories:	MAZ, MAZP
Hearing Rights:	Yes
Program ID:	GAE501
Transaction ID:	Authorization
Frequency:	Daily
Volume (est. monthly):	1400
Form Number:	DHS 8537

Notes:

0000072 WTLS 0032

HAMILTON COUNTY DEPT OF HUMAN SERVICES
222 E. CENTRAL PARKWAY

CINCINNATI OH 452020000

IMPORTANT NOTICE

JANE DOE
111 MAIN ST.

ANYWHERE, USA 11111-1111

Mailing Date: 05/13/1998
From: TERRI L SLAGHT
Phone: (513) 946-1838 Ext:

Worker ID: WTLS31
Case Number: 1111111111
AG Name: JANE DOE

Dear JANE DOE

Your **EXPEDITED MEDICAID APPLICATION** dated 04/16/1998 has been **APPROVED** effective 05/12/1998. You are eligible to receive Expedited Medicaid Benefits from 05/12/1998 through 07/10/1998. On 07/10/1998 your Expedited Medicaid eligibility will stop automatically without further notice.

You will receive an Expedited Medicaid card in the mail shortly. The Expedited Medicaid card will cover all Medicaid services (such as doctor's visits and prescriptions). However, it will **NOT** cover inpatient hospitalization.

Your eligibility for another public assistance program, such as Healthy Start or TANF-cash assistance, is being explored. If you are found eligible for one of these programs, inpatient hospitalization will be covered by that Medicaid card.

The following individuals are members of this assistance group:

JOHN D (INELIGIBLE) JANE D (ELIGIBLE)

REASON: ALL ELIGIBILITY REQUIREMENTS HAVE BEEN MET
The regulation supporting this action is contained in OHIO PUBLIC ASSISTANCE MANUAL Section 1020.

KEEP READING >>>

SEQ# 0020878 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000072
ODS 8537 (Rev. 12/96) 1111111111/MA Z/01 NOTICE TYPE: AE10M1

AG Name:	Case Number:	Mailing Date:
JANE DOE	1111111111	05/13/1998

YOUR RIGHT TO A STATE HEARING

This notice is to tell you about action we are taking on your case. If you do not understand this action, you should contact your caseworker. After talking to your caseworker, it is possible that we will change our decision or that you will agree with the action.

IF YOU DO NOT AGREE WITH THIS ACTION, YOU HAVE A RIGHT TO A STATE HEARING. A state hearing lets you or your representative (lawyer, welfare rights worker, friend, or relative) give your reasons against the action. We will also attend the hearing to present our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

If you want a hearing, we must receive your hearing request within 90 days of the mailing date on this notice.

If someone else makes a written hearing request for you, it must include a written statement, signed by you, telling us that person is your representative. Only you can make a request by telephone.

If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association toll free, at 1-800-589-5888, for the local number.

If you want a state hearing, check the appropriate box, sign and date this form, and send ALL PAGES to the Ohio Department of Human Services, State Hearings, 30 East Broad Street, 31st Floor, Columbus, Ohio 43266-0423.

☐ I want a county conference and a state hearing.

☐ I want a state hearing only.

I want a state hearing.

SIGNATURE	DATE	TELEPHONE NUMBER

END

Client Notice: AE21-A1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	December, 1997

Description of Notice:	Approval of disability medical assistance (all members are medication dependent).
Assistance Categories:	MA-G
Hearing Rights:	Yes
Program ID:	GAE501
Transaction ID:	Authorization
Frequency:	Daily
Volume (est. monthly):	1100
Form Number:	DHS 8521
Notes:	

0000034 WBMS 1405

CLARK COUNTY DEPT OF HUMAN SERVICES
1345 LAGONDA AVE

SPRINGFIELD OH 455030000

IMPORTANT NOTICE

JOHN DOE
111 MAIN ST.

ANYWHERE, USA 11111-1111

Mailing Date: 05/13/1998
From: BETSY M SHAW
Phone: (513) 327-1915 Ext:

Worker ID: WBMS12
Case Number: 1111111111
AG Name: JOHN DOE

Dear JOHN DOE

Your **APPLICATION** for **DISABILITY ASSISTANCE MEDICAL ASSISTANCE** dated 06/01/1998 has been **APPROVED** effective 04/24/1998.

RC: 091 MA G 3 A1

KEEP READING >>>

SEQ# 0017342 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000034
ODS 8521 (Rev. 12/97) 1111111111/MA G/03 NOTICE TYPE: AE21A1

AG Name:	Case Number:	Mailing Date:
JOHN DOE	1111111111	05/13/1998

YOUR RIGHT TO A STATE HEARING

This notice is to tell you about action we are taking on your case. If you do not understand this action, you should contact your caseworker. After talking to your caseworker, it is possible that we will change our decision or that you will agree with the action.

IF YOU DO NOT AGREE WITH THIS ACTION, YOU HAVE A RIGHT TO A STATE HEARING. A state hearing lets you or your representative (lawyer, welfare rights worker, friend or relative) give your reasons against the action. We will also attend the hearing to present our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

If you want a hearing we must receive your hearing request within 90 days of the mailing date on this notice. You do not need to return this form if you agree with the action.

If someone else makes a written hearing request for you, it must include a written statement, signed by you, telling us that person is your representative. Only you can make a request by telephone.

If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association, toll free at 1-(800)-589-5888, for the local number.

If you want a state hearing, check the appropriate box below, sign and date this form and send ALL PAGES to the Ohio Department of Human Services, State Hearings, 30 East Broad Street, 31st floor, Columbus, Ohio 43266-0423.

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

☐ I want a state hearing only.

I want a hearing.

SIGNATURE	DATE	TELEPHONE NUMBER

END

Client Notice: AE21-A3

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	December, 1997

Description of Notice:	Approval of disability assistance with retroactive benefits (all members are medication dependent).
Assistance Categories:	GA-A
Hearing Rights:	Yes
Program ID:	GAE501
Transaction ID:	Authorization
Frequency:	Daily
Volume (est. monthly):	700
Form Number:	DHS 8521

Notes:

0000029 WJAO 2141

CUYAHOGA COUNTY DEPT OF HUMAN SERVICES
NORTHEAST IMC 2100
12212 ST. CLAIR AVE
CLEVELAND OH 441080000

IMPORTANT NOTICE

JANE DOE
111 MAIN ST.

ANYWHERE, USA 11111-1111

Mailing Date: 05/08/1998
From: JACQUELINE A OGBONNA
Phone: (216) 987-7163 Ext:

Worker ID: WJAO18
Case Number: 1111111111
AG Name: JANE DOE

Dear JANE DOE

Your **APPLICATION** for **DISABILITY ASSISTANCE CASH BENEFITS** dated 05/07/1998 has been **APPROVED** for the period 05/07/1998 to 07/31/95, based on medication dependency. The amount of your check for that period will be $92.00. You will receive no further DA cash benefits because the Ohio General Assembly has passed Amended House Bill 249 ending Disability Assistance cash benefits based solely on medication dependency effective 07/31/1995.

RC: 525 GA A 1 A3

KEEP READING >>>

SEQ# 0016791 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000029
ODS 8521 (Rev. 12/97) 1111111111/GA A/01 NOTICE TYPE: AE21A3

AG Name:	Case Number:	Mailing Date:
JANE DOE	1111111111	05/08/1998

YOUR RIGHT TO A STATE HEARING

This notice is to tell you about action we are taking on your case. If you do not understand this action, you should contact your caseworker. After talking to your caseworker, it is possible that we will change our decision or that you will agree with the action.

IF YOU DO NOT AGREE WITH THIS ACTION, YOU HAVE A RIGHT TO A STATE HEARING. A state hearing lets you or your representative (lawyer, welfare rights worker, friend or relative) give your reasons against the action. We will also attend the hearing to present our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

If you want a hearing we must receive your hearing request within 90 days of the mailing date on this notice. You do not need to return this form if you agree with the action.

If someone else makes a written hearing request for you, it must include a written statement, signed by you, telling us that person is your representative. Only you can make a request by telephone.

If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association, toll free at 1-(800)-589-5888, for the local number.

If you want a state hearing, check the appropriate box below, sign and date this form and send ALL PAGES to the Ohio Department of Human Services, State Hearings, 30 East Broad Street, 31st floor, Columbus, Ohio 43266-0423.

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

☐ I want a state hearing only.

I want a hearing.

SIGNATURE	DATE	TELEPHONE NUMBER

END

Client Notice: AE21-A4

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	December, 1997

Description of Notice:	Approval of disability assistance with retroactive benefits (at least one member is medication dependent and one member eligible for DA under another covered group).
Assistance Categories:	GA-A
Hearing Rights:	Yes
Program ID:	GAE501
Transaction ID:	Authorization
Frequency:	Daily
Volume (est. monthly):	5
Form Number:	DHS 8521
Notes:	

WFAX 1012

IMPORTANT NOTICE

HURON COUNTY DEPT OF HUMAN SERVICES
580 SHADY GRAVE DRIVE

NORWALK OH 448570000

As of 06/01/1998 you have used 04 months of your initial 36 months of Ohio Works First benefit eligibility. If you continue to be eligible, you have 32 months remaining. After you have used up your 36 months, you might be eligible for additional months. See your caseworker.

JANE DOE
111 MAIN ST.

ANYWHERE, USA 11111-1111

Mailing Date: 06/02/1998
From : JOHN DOE
Phone: (301) 777-9311 Ext: 1111

Worker ID : WFAX00
Case Number : 4444444444
AG Name : JANE DOE

Dear JANE DOE

Your **APPLICATION** for **DISABILITY ASSISTANCE CASH BENEFITS** dated 06/01/1998 has been **APPROVED** effective 06/01/1998. Your monthly benefit amount will be $.00. Your first check will be for $115.00 which covers the period 05/16/1996 through 06/30/1996, 07/31/1996, 08/31/1996.

NOTE: The above amounts reflect the fact that one or more members of your assistance group qualify for Disability Assistance solely on the basis of medication dependency. The amount of any benefits after 08/01/95 does not include those individuals, because the Ohio General Assembly has passed Amended House Bill 249 ending Disability Assistance cash benefits based solely on medication dependency effective 07/31/1995.

RC: 091 375 525 GA A 1 A4

KEEP READING >>>

SEQ# 0006500 THIS SPACE FOR OFFICIAL USE ONLY
ODS 8521 (Rev. 12/97) 4444444444/GA A/01 NOTICE TYPE: AE21A4

AG Name:	Case Number:	Mailing Date:
JANE DOE	4444444444	06/02/1998

YOUR RIGHT TO A STATE HEARING

This notice is to tell you about action we are taking on your case. If you do not understand this action, you should contact your caseworker. After talking to your caseworker, it is possible that we will change our decision or that you will agree with the action.

IF YOU DO NOT AGREE WITH THIS ACTION, YOU HAVE A RIGHT TO A STATE HEARING. A state hearing lets you or your representative (lawyer, welfare rights worker, friend or relative) give your reasons against the action. We will also attend the hearing to present our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

If you want a hearing we must receive your hearing request within 90 days of the mailing date on this notice. You do not need to return this form if you agree with the action.

If someone else makes a written hearing request for you, it must include a written statement, signed by you, telling us that person is your representative. Only you can make a request by telephone.

If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association, toll free at 1-(800)-589-5888, for the local number.

If you want a state hearing, check the appropriate box below, sign and date this form and send ALL PAGES to the Ohio Department of Human Services, State Hearings, 30 East Broad Street, 31st floor, Columbus, Ohio 43266-0423.

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

☐ I want a state hearing only.

I want a hearing.

SIGNATURE	DATE	TELEPHONE NUMBER

END

Client Notice: AE21-D1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	December, 1997

Description of Notice:	Denial of all cash benefits. No eligibility for ADC or disability assistance.
Assistance Categories:	ADC, GA
Hearing Rights:	Yes
Program ID:	GAE501
Transaction ID:	Authorization
Frequency:	Daily
Volume (est. monthly):	30000
Form Number:	DHS 8521

Notes:

0000049 WMEM 0027

FAIRFIELD COUNTY DEPT OF HUMAN SERVICES
P.O. BOX 890

LANCASTER OH 431300000

IMPORTANT NOTICE

JANE DOE
111 MAIN ST.

ANYWHERE, USA 11111-1111

Mailing Date: 05/13/1998
From: MARTY E MOORE
Phone: (614) 653-1701 Ext:

Worker ID: WMEM23
Case Number: 1111111111
AG Name: JANE DOE

Dear JANE DOE

Your **APPLICATION** for **CASH ASSISTANCE** dated 05/12/1998 has been **DENIED** effective 05/12/1998.

The following individuals are members of this assistance group:

JANE D (INELIGIBLE) JOHN D (INELIGIBLE)

REASON: You don't qualify for TANF because there are no children in your assistance group deprived because of absence, incapacity, or unemployment. You don't qualify for Disability Assistance based on age (under 18, 60 or over), living arrangement, disability, pregnancy, or residential treatment for subtance abuse.
The regulations supporting this action are found in OHIO PUBLIC ASSISTANCE MANUAL Chapters 3000 (TANF) and 5000 (DA).

RC: GA U 1 D1

KEEP READING >>>

SEQ# 0016753 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000049
ODS 8521 (Rev. 12/97) 1111111111/GA U/01 NOTICE TYPE: AE21D1

Your **APPLICATION** for **MEDICAL ASSISTANCE** dated 05/12/1998 has been **DENIED** effective 05/12/1998.

The following individuals are members of this assistance group:

JANE D (INELIGIBLE) JOHN D (INELIGIBLE)

REASON: You don't qualify for Medicaid based on age (65 or over), blindness, or disability. You don't qualify for TANF because there are no children in your assistance group deprived due to absence, incapacity, or unemployment. You don't qualify for Disability Assistance based on age (under 18, 60 or over), living arrangement, disability, pregnancy, medication dependency, or residential treatment for subtance abuse.
The regulations supporting this action are found in OHIO PUBLIC ASSISTANCE MANUAL Chapters 3000 (TANF) and 5000 (DA), 7000 (MEDICAID) and 11000 (TRANSITIONAL MEDICAID).

RC: MA G 1 D2

KEEP READING >>>

AG Name:	Case Number:	Mailing Date:
JANE DOE	1111111111	05/13/1998

YOUR RIGHT TO A STATE HEARING

This notice is to tell you about action we are taking on your case. If you do not understand this action, you should contact your caseworker. After talking to your caseworker, it is possible that we will change our decision or that you will agree with the action.

IF YOU DO NOT AGREE WITH THIS ACTION, YOU HAVE A RIGHT TO A STATE HEARING. A state hearing lets you or your representative (lawyer, welfare rights worker, friend or relative) give your reasons against the action. We will also attend the hearing to present our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

If you want a hearing we must receive your hearing request within 90 days of the mailing date on this notice. You do not need to return this form if you agree with the action.

If someone else makes a written hearing request for you, it must include a written statement, signed by you, telling us that person is your representative. Only you can make a request by telephone.

If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association, toll free at 1-(800)-589-5888, for the local number.

If you want a state hearing, check the appropriate box below, sign and date this form and send ALL PAGES to the Ohio Department of Human Services, State Hearings, 30 East Broad Street, 31st floor, Columbus, Ohio 43266-0423.

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

☐ I want a state hearing only.

I want a hearing.

SIGNATURE	DATE	TELEPHONE NUMBER

END

Client Notice: AE21-D2

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	December, 1997

Description of Notice:	Denial of medical benefits
Assistance Categories:	MA-G
Hearing Rights:	Yes
Program ID:	GAE501
Transaction ID:	Authorization
Frequency:	Daily
Volume (est. monthly):	34000
Form Number:	DHS 8521

Notes:

IMPORTANT NOTICE

FAIRFIELD COUNTY DEPT OF HUMAN SERVICES
P.O. BOX 100

KINSINGTY OH 431300000

As of 06/01/1998 you have used 04 months of your initial 36 months of Ohio Works First benefit eligibility. If you continue to be eligible, you have 32 months remaining. After you have used up your 36 months, you might be eligible for additional months. See your caseworker.

JOHN DOE
111 MAIN ST.

ANYWHERE, USA 11111-1111

Mailing Date: 06/02/1998
From : JANE DOE
Phone: (301) 777-9311 Ext: 1111

Worker ID : WFAX00
Case Number : 7777777777
AG Name : JOHN DOE

Dear JOHN DOEN

Your **APPLICATION** for **MEDICAL ASSISTANCE** dated 06/01/1998 has been **DENIED** effective 08/07/1996.

The following individuals are members of this assistance group:

JOHN D (INELIGIBLE)

REASON: You don't qualify for Medicaid based on age (65 or over), blindness, or disability. You don't qualify for TANF because there are no children in your assistance group deprived due to absence, incapacity, or unemployment. You don't qualify for Disability Assistance based on age (under 18, 60 or over), living arrangement, disability, pregnancy, medication dependency, or residential treatment for subtance abuse. The regulations supporting this action are found in OHIO PUBLIC ASSISTANCE MANUAL Chapters 3000 (TANF) and 5000 (DA), 7000 (MEDICAID) and 11000 (TRANSITIONAL MEDICAID).

RC: MA G 1 D2

KEEP READING >>>

AG Name:	Case Number:	Mailing Date:
JOHN DOE	7777777777	06/02/1998

YOUR RIGHT TO A STATE HEARING

This notice is to tell you about action we are taking on your case. If you do not understand this action, you should contact your caseworker. After talking to your caseworker, it is possible that we will change our decision or that you will agree with the action.

IF YOU DO NOT AGREE WITH THIS ACTION, YOU HAVE A RIGHT TO A STATE HEARING. A state hearing lets you or your representative (lawyer, welfare rights worker, friend or relative) give your reasons against the action. We will also attend the hearing to present our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

If you want a hearing we must receive your hearing request within 90 days of the mailing date on this notice. You do not need to return this form if you agree with the action.

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If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association, toll free at 1-(800)-589-5888, for the local number.

If you want a state hearing, check the appropriate box below, sign and date this form and send ALL PAGES to the Ohio Department of Human Services, State Hearings, 30 East Broad Street, 31st floor, Columbus, Ohio 43266-0423.

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

☐ I want a state hearing only.

I want a hearing.

SIGNATURE	DATE	TELEPHONE NUMBER

END

Client Notice: AE21-D3

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	December, 1997

Description of Notice:	Denial of disability assistance with no retroactive benefits.
Assistance Categories:	GA-A, MA-G
Hearing Rights:	Yes
Program ID:	GAE501
Transaction ID:	Authorization
Frequency:	Daily
Volume (est. monthly):	109000
Form Number:	DHS 8521

Notes:

0000001 WDAB 0022

FAIRFIELD COUNTY DEPT OF HUMAN SERVICES
P.O. BOX 890

LANCASTER OH 431300000

IMPORTANT NOTICE

JANE DOE
111 MAIN ST

ANYWHERE, OH 99999-9999

Mailing Date: 04/05/1999
From: DEBORAH K BASH
Phone: (614) 653-1701 Ext: 6718

Worker ID: WDAB23
Case Number: 9999999999
AG Name: JANE DOE

Dear JANE DOE

We DENIED your **DISABILITY ASSISTANCE (DA) application of** 04/01/1999.

The following individuals are members of this assistance group:

JANE D (INELIGIBLE)

REASON:
THE ASSISTANCE GROUP'S COUNTABLE INCOME IS MORE THAN THE $ 115.00
PAYMENT STANDARD FOR A 1 MEMBER ASSISTANCE GROUP .
The regulation supporting this action is contained in OHIO ADMINISTRATIVE CODE, Section 5101:1-5-40

RC: 398 GA A 1 D3

KEEP READING >>>

SEQ# 0011762 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000001
ODS 8521 (Rev. 12/96) 9999999999/GA A/01 NOTICE TYPE: AE21D3

AG Name:	Case Number:	Mailing Date:
JANE DOE	9999999999	04/05/1999

YOUR RIGHT TO A STATE HEARING

This notice is to tell you about action we are taking on your case. If you do not understand this action, you should contact your caseworker. After talking to your caseworker, it is possible that we will change our decision or that you will agree with the action.

IF YOU DO NOT AGREE WITH THIS ACTION, YOU HAVE A RIGHT TO A STATE HEARING. A state hearing lets you or your representative (lawyer, welfare rights worker, friend or relative) give your reasons against the action. We will also attend the hearing to present our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

If you want a hearing we must receive your hearing request within 90 days of the mailing date on this notice. You do not need to return this form if you agree with the action.

If someone else makes a written hearing request for you, it must include a written statement, signed by you, telling us that person is your representative. Only you can make a request by telephone.

If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association, toll free at 1-(800)-589-5888, for the local number.

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

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

☐ I want a state hearing only.

I want a hearing.

SIGNATURE	DATE	TELEPHONE NUMBER

END

Client Notice: AE22-A1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	December, 1997

Description of Notice:	Retroactve approval of general assistance cash; ongoing eligibility
Assistance Categories:	GA-U
Hearing Rights:	Yes
Program ID:	GAE501
Transaction ID:	Authorization
Frequency:	Daily
Volume (est. monthly):	3200
Form Number:	DHS8522
Notes:	

WFAX 1017

IMPORTANT NOTICE

FRANKLIN COUNTY DEPT OF HUMAN SERVICES
80 E. SALTIN ST.

COLUMBUS OH 432150000

As of 06/01/1998 you have used 04 months of your initial 36 months of Ohio Works First benefit eligibility. If you continue to be eligible, you have 32 months remaining. After you have used up your 36 months, you might be eligible for additional months. See your caseworker.

JANE DOE
111 MAIN ST.

ANYWHERE, USA 11111-1111

Mailing Date: 06/02/1998
From: RANDY BOONE
Phone: (301) 777-9311 Ext: 1111

Worker ID: WFAX00
Case Number: 9999999999
AG Name: JANE DOE

DearJANE DOE

Your **APPLICATION** for **GENERAL ASSISTANCE CASH BENEFITS** dated 06/01/1998 has been **APPROVED** for the period 06/01/1998 to 10/01/1998. The amount of your check for that period will be $.00. You will receive no further cash benefits because the Ohio General Assembly has passed Amended House Bill 249 ending the General Assistance cash program effective 07/31/1995.

REASON: ALL ELIGIBILITY REQUIREMENTS HAVE BEEN MET
The regulation supporting this action is contained in OHIO PUBLIC ASSISTANCE MANUAL Section 01020

RC: 091 MA G 1 A1

KEEP READING >>>

SEQ# 0006900 THIS SPACE FOR OFFICIAL USE ONLY
ODS 8522 (Rev. 12/97) 9999999999/MA G/01 NOTICE TYPE: AE22A1

AG Name:	Case Number:	Mailing Date:
JANE DOE	9999999999	06/02/1998

YOUR RIGHT TO A STATE HEARING

This notice is to tell you about action we are taking on your case. If you do not understand this action, you should contact your caseworker. After talking to your caseworker, it is possible that we will change our decision or that you will agree with the action.

IF YOU DO NOT AGREE WITH THIS ACTION, YOU HAVE A RIGHT TO A STATE HEARING.

> **NOTE:** Because the end of the General Assistance program 07/31/95 is the result of a change in the law, you cannot have a hearing on it. However, you can have a hearing if you disagree with decisions we have made on your benefits for periods before 08/01/1995.

A state hearing lets you or your representative (lawyer, welfare rights worker, friend or relative) give your reasons against the action. We will also attend the hearing to present our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

If you want a hearing we must receive your hearing request within 90 days of the mailing date on this notice. You do not need to return this form if you agree with the action.

If someone else makes a written hearing request for you, it must include a written statement, signed by you, telling us that person is your representative. Only you can make a request by telephone.

If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association, toll free at 1-(800)-589-5888, for the local number.

If you want a state hearing, check the appropriate box below, sign and date this form and send ALL PAGES to the Ohio Department of Human Services, State Hearings, 30 East Broad Street, 31st floor, Columbus, Ohio 43266-0423.

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

☐ I want a state hearing only.

I want a hearing.

SIGNATURE	DATE	TELEPHONE NUMBER

END

Client Notice: AE22-A2

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	December, 1997

Description of Notice:	Retroactive approval of General Assistance medical benefits. No ongoing eligibility.
Assistance Categories:	MA-G
Hearing Rights:	Yes
Program ID:	GAE501
Transaction ID:	Authorization
Frequency:	Daily
Volume (est. monthly):	6500
Form Number:	DHS8522
Notes:	

Client Notice: AE22-D3

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	December, 1997

Description of Notice:	GA-U denial for reasons unrelated to AM. H. B. 249, which ended the general assistance program 7-31-95.
Assistance Categories:	GA-U
Hearing Rights:	Yes
Program ID:	GAE501
Transaction ID:	Authorization
Frequency:	Daily
Volume (est. monthly):	35
Form Number:	DHS 8522

Notes:

Client Notice: AE24-C1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	December, 1997

Description of Notice:	Continuation of ADC-related medicaid benefits when an ADC recipient is sanctioned for failure to cooperate with learnfare.
Assistance Categories:	MA C
Hearing Rights:	Yes
Program ID:	GAE501
Transaction ID:	Authorization
Frequency:	Daily
Volume (est. monthly):	
Form Number:	DHS AE24
Notes:	The action on this notice accompanies notice AE24L1.

0000001 WCJM 1117

ALLEN COUNTY DEPT OF HUMAN SERVICES
P.O.BOX 4506

LIMA OH 458020000

IMPORTANT NOTICE

JANE DOE
111 MAIN ST.

ANYWHERE, USA 11111-1111

Mailing Date: 07/24/1996
From: CHARLOTTE J MAVIS
Phone: (419) 228-2621 Ext:

Worker ID: WCJM02
Case Number: 1111111111
AG Name: JANE DOE

Dear JANE DOE

Your **ADC-RELATED MEDICAID** benefits will **CONTINUE** with no change.

The following individuals are affected by this action:

JOETT M (INELIGIBLE) ALLEN M (ELIGIBLE)

REASON: LEARNFARE REFUSAL TO CONSENT SANCTION APPLIED
EFFECTIVE 08/01/96 , THE FOLLOWING INDIVIDUALS ARE NOT ELIGIBLE TO BE INCLUDED IN THE ADC PAYMENT BECAUSE OF REFUSAL TO CONSENT TO THE RELEASE OF SCHOOL INFORMATION: ALLEN MARTI
The regulation supporting this action is contained in OHIO PUBLIC ASSISTANCE MANUAL Section 01010

RC: 532 MA C 1 C1

KEEP READING >>>

SEQ# 0007000 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000001
ODS 8524 (Rev. 12/97) 1111111111/MA C/01 NOTICE TYPE: AE24C1

AG Name:	Case Number:	Mailing Date:
JANE DOE	1111111111	07/24/1996

YOUR RIGHT TO A STATE HEARING

This notice is to tell you about action we are taking on your case. If you do not understand this action, you should contact your caseworker. After talking to your caseworker, it is possible that we will change our decision or that you will agree with the action.

IF YOU DO NOT AGREE WITH THIS ACTION, YOU HAVE A RIGHT TO A STATE HEARING.

A state hearing lets you or your representative (lawyer, welfare rights worker, friend or relative) give your reasons against the action. We will also attend the hearing to present our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

If you want a hearing we must receive your hearing request within 90 days of the mailing date on this notice. You do not need to return this form if you agree with the action.

If we receive your request by **08/08/1996**, the action will not be taken until the state hearing is decided. If you lose your hearing, you may have to pay back benefits that you were not eligible to receive.

If someone else makes a written hearing request for you, it must include a written statement, signed by you, telling us that person is your representative. Only you can make a request by telephone.

If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association, toll free at 1-(800)-589-5888, for the local number.

If you want a state hearing, check the appropriate box below, sign and date this form and send ALL PAGES to the Ohio Department of Human Services, State Hearings, 30 East Broad Street, 31st floor, Columbus, Ohio 43266-0423.

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

☐ I want a state hearing only.

I want a hearing.

SIGNATURE	DATE	TELEPHONE NUMBER

END

Client Notice: AE24-L1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	6/1/96
Last Date Revised:	December, 1997

Description of Notice:	Reduction in ADC benefits; refusal to sign learnfare consent form
Assistance Categories:	ADCI, ADCR
Hearing Rights:	Yes
Program ID:	GAE501
Transaction ID:	Authorization
Frequency:	Daily
Volume (est. monthly):	
Form Number:	DHS AE24
Notes:	This notice replaced AE01L2 which are only used in Allen and Shelby Counties.

WFAX 1117

IMPORTANT NOTICE

ALLEN COUNTY DEPT OF HUMAN SERVICES
P.O.BOX 5900

LIMA OH 458020000

As of 06/01/1998 you have used 04 months of your initial 36 months of Ohio Works First benefit eligibility. If you continue to be eligible, you have 32 months remaining. After you have used up your 36 months, you might be eligible for additional months. See your caseworker.

JOHN DOE
111 MAIN ST.

ANYWHERE, USA 11111-1111

Mailing Date: 06/02/1998
From : JOHN DOE P
Phone: (301) 777-9311 Ext: 1111

Worker ID : WFAX00
Case Number : 2000000000
AG Name : JOHN DOE

Dear JOHN DOE

Your **OHIO WORKS FIRST (OWF)** benefits will be **REDUCED** from $183.00 to $.00 beginning 06/01/1998 because one or more members of your assistance group have failed to cooperate with the Learnfare program. Those individuals will be removed from the OWF payment.

This reduction will continue until you cooperate by consenting to the exchange of school attendance and other information between the school and this department. If you wish to cooperate, contact your caseworker.

REASON: LEARNFARE REFUSAL TO CONSENT SANCTION APPLIED
EFFECTIVE 08/01/96 , THE FOLLOWING INDIVIDUALS ARE NOT ELIGIBLE TO BE INCLUDED IN THE TANF PAYMENT BECAUSE OF REFUSAL TO CONSENT TO THE RELEASE OF SCHOOL INFORMATION: ALLEN MARTI
The regulation supporting this action is contained in OHIO PUBLIC ASSISTANCE MANUAL Section 04702

RC: 532 ADCR 1 L1

KEEP READING >>>

SEQ# 0007100 THIS SPACE FOR OFFICIAL USE ONLY
ODS 8524 (Rev. 12/97) 2000000000/ADCR/01 NOTICE TYPE: AE24L1

AG Name:	Case Number:	Mailing Date:
JOHN DOE	2000000000	06/02/1998

YOUR RIGHT TO A STATE HEARING

This notice is to tell you about action we are taking on your case. If you do not understand this action, you should contact your caseworker. After talking to your caseworker, it is possible that we will change our decision or that you will agree with the action.

IF YOU DO NOT AGREE WITH THIS ACTION, YOU HAVE A RIGHT TO A STATE HEARING.

A state hearing lets you or your representative (lawyer, welfare rights worker, friend or relative) give your reasons against the action. We will also attend the hearing to present our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

If you want a hearing we must receive your hearing request within 90 days of the mailing date on this notice. You do not need to return this form if you agree with the action.

If we receive your request by **08/08/1996**, the action will not be taken until the state hearing is decided. If you lose your hearing, you may have to pay back benefits that you were not eligible to receive.

If someone else makes a written hearing request for you, it must include a written statement, signed by you, telling us that person is your representative. Only you can make a request by telephone.

If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association, toll free at 1-(800)-589-5888, for the local number.

If you want a state hearing, check the appropriate box below, sign and date this form and send ALL PAGES to the Ohio Department of Human Services, State Hearings, 30 East Broad Street, 31st floor, Columbus, Ohio 43266-0423.

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

☐ I want a state hearing only.

I want a hearing.

SIGNATURE	DATE	TELEPHONE NUMBER

END

Client Notice: AE24-L2

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	6/1/96
Last Date Revised:	December, 1997

Description of Notice:	One month learnfare attendance ADC reduction sanction
Assistance Categories:	ADCI, ADCP, ADCR, ADCQ, ADCU
Hearing Rights:	Yes
Program ID:	GAE501
Transaction ID:	Authorization
Frequency:	Daily
Volume (est. monthly):	
Form Number:	DHS AE24
Notes:	Replaced AE01L3 on 9/6/95 which is used only at Allen and Shelby counties.

0000013 WSKS 2333

ALLEN COUNTY DEPT OF HUMAN SERVICES
P.O.BOX 4506

LIMA OH 458020000

IMPORTANT NOTICE

As of 05/12/1998 you have used 07 months of your initial 36 months of Ohio Works First benefit eligibility. If you continue to be eligible, you have 29 months remaining. After you have used up your 36 months, you might be eligible for additional months. See your caseworker.

JANE DOE
111 MAIN ST.
APT 0
ANYWHERE, USA 11111-1111

Mailing Date: 05/13/1998
From: SUSAN K SMITH
Phone: (419) 228-2621 Ext:

Worker ID: WSKS02
Case Number: 1111111111
AG Name: JANE DOE

Dear JANE DOE

Your **OHIO WORKS FIRST (OWF)** benefits will be **REDUCED** from $721.00 to $650.00 for the month of 06/1998. The reason for this reduction is the failure of one or more members of your assistance group to meet the Learnfare school attendance requirement for the month of 03/1998. Those individuals are being removed for one month from the OWF payment.

If future school attendance is satisfactory, this reduction of you OWF payment will stop the next month.

The regulation supporting this action is contained in the **OHIO PUBLIC ASSISTANCE MANUAL** Section 4702.

RC: 533 ADCR 1 L2

KEEP READING >>>

SEQ# 0020877 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000013
ODS 8524 (Rev. 12/97) 1111111111/ADCR/01 NOTICE TYPE: AE24L2

AG Name:	Case Number:	Mailing Date:
JANE DOE	1111111111	05/13/1998

YOUR RIGHT TO A STATE HEARING

This notice is to tell you about action we are taking on your case. If you do not understand this action, you should contact your caseworker. After talking to your caseworker, it is possible that we will change our decision or that you will agree with the action.

IF YOU DO NOT AGREE WITH THIS ACTION, YOU HAVE A RIGHT TO A STATE HEARING.

A state hearing lets you or your representative (lawyer, welfare rights worker, friend or relative) give your reasons against the action. We will also attend the hearing to present our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

If you want a hearing we must receive your hearing request within 90 days of the mailing date on this notice. You do not need to return this form if you agree with the action.

If we receive your request by **05/28/1998**, the action will not be taken until the state hearing is decided. If you lose your hearing, you may have to pay back benefits that you were not eligible to receive.

If someone else makes a written hearing request for you, it must include a written statement, signed by you, telling us that person is your representative. Only you can make a request by telephone.

If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association, toll free at 1-(800)-589-5888, for the local number.

If you want a state hearing, check the appropriate box below, sign and date this form and send ALL PAGES to the Ohio Department of Human Services, State Hearings, 30 East Broad Street, 31st floor, Columbus, Ohio 43266-0423.

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

☐ I want a state hearing only.

I want a hearing.

SIGNATURE	DATE	TELEPHONE NUMBER

END

Client Notice: AE25-L1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	6/1/96
Last Date Revised:	December, 1997

Description of Notice:	Leanfare warning notice informing participant in learnfare of first infraction and penalty for second
Assistance Categories:	
Hearing Rights:	Yes
Program ID:	GAE005
Transaction ID:	AELFD
Frequency:	Daily
Volume (est. monthly):	
Form Number:	DHS AE25
Notes:	

WFAX 1117

IMPORTANT NOTICE

ALLEN COUNTY DEPT OF HUMAN SERVICES
P.O.BOX 4506

LIMA OH 458020000

As of 06/01/1998 you have used 04 months of your initial 36 months of Ohio Works First benefit eligibility. If you continue to be eligible, you have 32 months remaining. After you have used up your 36 months, you might be eligible for additional months. See your caseworker.

JOHN DOE
111 MAIN ST.

ANYWHERE, USA 11111-1111

Mailing Date: 06/02/1998
From: HANSEL H HOLBERT
Phone: (301) 777-9311 Ext: 1111

Worker ID: WFAX00
Case Number: 5555555555
AG Name: JOHN DOE

Dear JOHN DOE

School authorities have reported that , who is a participant in the Learnfare program, had three or more unexcused absences during 00/0000. Although we are not proposing any penalty at this time, this will be considered a first occurrence, and may result in a penalty if there are further attendance problems within this school year. The penalty for a second failure to meet the Learnfare attendance requirements will be a reduction of your Ohio Works First (OWF) payment to the amount your family would get if was not included.

If there was a good reason for these absences, you may want to ask for a state hearing. For more information on state hearings, read the rest of this notice.

The regulation supporting this action is contained in the **OHIO PUBLIC ASSISTANCE MANUAL** Section 4702.

KEEP READING >>>

AG Name:	Case Number:	Mailing Date:
JOHN DOE	5555555555	06/02/1998

YOUR RIGHT TO A STATE HEARING

This notice is to tell you about action we are taking on your case. If you do not understand this action, you should contact your caseworker. After talking to your caseworker, it is possible that we will change our decision or that you will agree with the action.

IF YOU DO NOT AGREE WITH THIS ACTION, YOU HAVE A RIGHT TO A STATE HEARING. A state hearing lets you or your representative (lawyer, welfare rights worker, friend or relative) give your reasons against the action. We will also attend the hearing to present our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

If you want a hearing, we must receive your hearing request within 90 days of the mailing date on this notice.

If someone else makes a written hearing request for you, it must include a written statement, signed by you, telling us that person is your representative. Only you can make a request by telephone.

If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association toll free, at 1-(800)-589-5888, for the local number.

If you want a state hearing, check the appropriate box, sign and date this form, and send ALL PAGES to the Ohio Department of Human Services, State Hearings, 30 East Broad Street, 31st Floor, Columbus, Ohio 43266-0423.

☐ I want a county conference and a state hearing.

☐ I want a state hearing only.

I want a state hearing.

SIGNATURE	DATE	TELEPHONE NUMBER

END

Client Notice: AR01-J1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	December, 1997

Description of Notice:	Hospital Referral Notice - Initial (notice sent to client)
Assistance Categories:	APPL's only
Hearing Rights:	No
Program ID:	GAR030
Transaction ID:	
Frequency:	Weekly
Volume (est. monthly):	3000
Form Number:	DHS 8506
Notes:	

0000037 WBJH

FRANKLIN COUNTY DEPT OF HUMAN SERVICES
80 E. FULTON ST.

COLUMBUS OH 432150000

IMPORTANT NOTICE

JOHN DOE
111 MAIN ST.

ANYWHERE, USA 11111-1111

Mailing Date: 05/11/1998
From: BRENDA J HODGE
Phone: (614) 462-4319 Ext:

Worker ID: WBJH25
Case Number: 1111111111
AG Name:

HOSPITAL INFORMATION

Application Number: 1111111111
Hospital: MT CARMEL HOSP

Patient:
Admission Date: 02/23/1998

Dear

We were notified on 05/05/1998 by MT CARMEL HOSP that you might need assistance from the FRANKLIN County Department of Human Services in paying for this hospitalization.

If you wish to make an application, you, or your representative must come to our agency or give us a call by 05/26/1998, and file an application within 60 days from your discharge from the hospital.

If you call, an appointment notice will be mailed to you. You will be required to come to our agency on your appointment date to determine your eligibility.

If you do not come in or call for an appointment, if you fail to file an application or fail to keep your appointment, we will notify the hospital of your failure to complete the application process and of their need to contact you for payment of the hospital bill, as we will be denying assistance to you.

NOTE: THIS HOSPITAL BILL IS YOUR RESPONSIBILITY. IT WILL NOT BE AUTOMATICALLY APPROVED. YOU MUST FILE AN APPLICATION WITH US BEFORE WE CAN DETERMINE YOUR ELIGIBILITY FOR ASSISTANCE.

If you do not understand or have questions about this notice, please contact the worker named above.

END

SEQ# 0024869 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000037
ODS 8506 (Rev. 12/97) 1111111111//00 NOTICE TYPE: AR01J1

Client Notice: AR02-J2

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	December, 1997

Description of Notice:	Hospital Referral Notice - Second (sent to client)
Assistance Categories:	APPL's only
Hearing Rights:	No
Program ID:	GAR030
Transaction ID:	
Frequency:	Weekly
Volume (est. monthly):	1000
Form Number:	DHS 8507
Notes:	

0000047 WBJH

FRANKLIN COUNTY DEPT OF HUMAN SERVICES
80 E. FULTON ST.

COLUMBUS OH 432150000

IMPORTANT NOTICE

JANE DOE
111 MAIN ST.
ANYWHERE, USA 11111-1111

Mailing Date: 05/11/1998
From: BRENDA J HODGE
Phone: (614) 462-4319 Ext:

Worker ID: WBJH25
Case Number: 1111111111
AG Name:

HOSPITAL INFORMATION

Application Number: 1111111111
Hospital: HOCKING VALLEY COMM. HOSP.

Patient:
Admission Date: 04/06/1998

Dear

We were notified on 04/22/1998 by HOCKING VALLEY COMM. HOSP. that you might need assistance from the FRANKLIN County Department of Human Services in paying for this hospitalization.

If you wish to make an application, you, or your representative must come to our agency or give us a call by 05/22/1998, and file an application within 60 days from your discharge from the hospital.

If you call, an appointment notice will be mailed to you. You will be required to come to our agency on your appointment date to determine your eligibility.

If you do not come in or call for an appointment, if you fail to file an application or fail to keep your appointment, we will notify the hospital of your failure to complete the application process and of their need to contact you for payment of the hospital bill, as we will be denying assistance to you.

NOTE: THIS HOSPITAL BILL IS YOUR RESPONSIBILITY. IT WILL NOT BE AUTOMATICALLY APPROVED. YOU MUST FILE AN APPLICATION WITH US BEFORE WE CAN DETERMINE YOUR ELIGILIBILITY FOR ASSISTANCE.

THIS IS YOUR SECOND AND FINAL NOTICE. FAILURE TO FILE AN APPLICATION WILL RESULT IN A DENIAL OF ASSISTANCE IN PAYING THIS HOSPITAL BILL.

If you do not understand or have questions about this notice, please contact the worker named above.

END

SEQ# 0025389 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000047
ODS 8507 (Rev. 12/97) 1111111111//00 NOTICE TYPE: AR02J2

Client Notice: AR03-J3

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	December, 1997

Description of Notice:	Hospital Referral Notice - Non-Compliance (sent to provider)
Assistance Categories:	APPL's only
Hearing Rights:	No
Program ID:	GAR030
Transaction ID:	
Frequency:	Weekly
Volume (est. monthly):	1000
Form Number:	DHS 8508
Notes:	

0000016 WJAC

COLUMBIANA COUNTY DEPT OF HUMAN SERVICES
P.O. BOX 9

LISBON OH 444320000

IMPORTANT NOTICE

AGENERAL HOSPITAL
111 MAIN ST.

ANYWHERE, USA 11111-1111

Mailing Date: 05/11/1998
From: JANICE M CORBIN
Phone: (330) 424-1471 Ext: 0074

Worker ID: WJAC15
Case Number: 1111111111
AG Name: JOHN DOE

HOSPITAL INFORMATION

Application Number: 1111111111
Hospital: GENERAL HOSPITAL

Patient: JOHN DOE
Admission Date: 04/14/1998

Dear GENERAL HOSPITAL

In compliance with the Ohio Public Assistance Manual Section 1015.1, we are notifying you that the above named patient has not made an appointment, has not filed an application, or has not kept a previously scheduled appointment to determine eligibility for payment of this hospital stay.

You have until 05/20/1998 to work with the patient and assist him/her in making an application with us. Patient non-cooperation in filing an application within 30 days will result in denial of this bill.

If you do not understand or have questions about this notice, please contact the worker named above.

END

SEQ# 0025818 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000016
ODS 8508 (Rev. 12/97) 1111111111//00 NOTICE TYPE: AR03J3

Client Notice: AR04-D1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	December, 1997

Description of Notice:	Notice of Denial
Assistance Categories:	APPL's only
Hearing Rights:	Yes
Program ID:	GAR005
Transaction ID:	ARAD
Frequency:	Daily
Volume (est. monthly):	3000
Form Number:	DHS 8509

Notes:

0000041 WFMC 0000

DELAWARE COUNTY DEPT OF HUMAN SERVICES
149 N. SANDUSKY ST.

DELAWARE OH 430150000

IMPORTANT NOTICE

JANE DOE
111 MAIN ST.

ANYWHERE, USA 11111-1111

Mailing Date: 05/13/1998
From: FRAN M COOK
Phone: (614) 368-1990 Ext:

Worker ID: WFMC21
Case Number: 1111111111
AG Name:

Dear

Please read this notice carefully. After a review of your circumstances, we have determined the following:

Your application dated 05/07/1998 has been **DENIED** effective 05/12/1998.
The following individuals are affected by this action:

JANE D

REASON: VOLUNTARY WITHDRAWAL OF INITIAL APPLICATION
The regulation supporting this action is contained in OHIO PUBLIC ASSISTANCE MANUAL Section 1019.

KEEP READING >>>

SEQ# 0020934 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000041
ODS 8509(Rev. 12/97) 1111111111//00 NOTICE TYPE: AR04D1

AG Name:	Case Number: 1111111111	Mailing Date: 05-13-1998

YOUR RIGHT TO A STATE HEARING

This notice is to tell you about action we are taking on your case. If you do not understand this action, you should contact your caseworker. After talking to your caseworker, it is possible that we will change our decision or that you will agree with the action.

IF YOU DO NOT AGREE WITH THIS ACTION, YOU HAVE A RIGHT TO A STATE HEARING, unless you have already had a hearing on the amount of the claim. A state hearing lets you or your representative (lawyer, welfare rights worker, friend, or relative) give your reasons against the action. We will also attend the hearing to present our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

If you want a hearing, we must receive your hearing request within 90 days of the mailing date on this notice.

If someone else makes a written hearing request for you, it must include a written statement, signed by you, telling us that person is your representative. Only you can make a request by telephone.

If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association toll free, at 1-800-589-5888, for the local number.

If you want a state hearing, check the appropriate box, sign and date this form, and send ALL PAGES to the Ohio Department of Human Services, State Hearings, 30 East Broad Street, 31st Floor, Columbus, Ohio 43266-0423.

☐ I want a county conference and a state hearing.

☐ I want a state hearing only.

I want a state hearing.

SIGNATURE	DATE	TELEPHONE NUMBER

END

Client Notice: BI01-X1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	December, 1997

Description of Notice:	Notice of Underpayment; Accompanied by either a BI01X5 and/or a BI01X2.
Assistance Categories:	All
Hearing Rights:	Yes
Program ID:	GCU023
Transaction ID:	CU023
Frequency:	Daily
Volume (est. monthly):	9000
Form Number:	DHS 8510
Notes:	Under issuance claims

0000074 WMTC 0082

HAMILTON COUNTY DEPT OF HUMAN SERVICES
222 E. CENTRAL PARKWAY

CINCINNATI OH 452020000

IMPORTANT NOTICE

JANE DOE
111 MAIN ST.

ANYWHERE USA, 11111-1111

Mailing Date: 05/13/1998
From: MS. M CORDRAY
Phone: (513) 946-1311 Ext:

Worker ID: WMTC31
Case Number: 1111111111
AG Name: JANE DOE

Dear JANE DOE

After a careful review, we have determined that from 03/01/1998 through 04/30/1998, your assistance group received $194.00 less in FOOD STAMP benefits than you were eligible to receive.

FS 1 X1

You will receive an auxiliary FOOD STAMP benefit in the amount of 194.00. This benefit covers the period from 03/01/1998 through 04/30/1998.

FS 1 X2

KEEP READING >>>

SEQ# 0020742 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000074
ODS 8510 (Rev. 12/97) 1111111111/FS /01 NOTICE TYPE: BI01X1

AG Name:	Case Number:	Mailing Date:
JANE DOE	1111111111	05/13/1998

YOUR RIGHT TO A STATE HEARING

This notice is to tell you about action we are taking on your case. If you do not understand this action, you should contact your caseworker. After talking to your caseworker, it is possible that we will change our decision or that you will agree with the action.

IF YOU DO NOT AGREE WITH THIS ACTION, YOU HAVE A RIGHT TO A STATE HEARING.

A state hearing lets you or your representative (lawyer, welfare rights worker, friend or relative) give your reasons against the action. We will also attend the hearing to present our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

If you want a hearing we must receive your hearing request within 90 days of the mailing date on this notice.

If someone else makes a written hearing request for you, it must include a written statement, signed by you, telling us that person is your representative. Only you can make a request by telephone.

If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association, toll free at 1-(800)-589-5888, for the local number.

If you want a state hearing, check the appropriate box below, sign and date this form and send ALL PAGES to the Ohio Department of Human Services, State Hearings, 30 East Broad Street, 31st floor, Columbus, Ohio 43266-0423.

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

☐ I want a state hearing only.

I want a hearing.

SIGNATURE	DATE	TELEPHONE NUMBER

END

Client Notice: BI01-X2

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	July, 2000

Description of Notice:	Notice of auxilliary check to correct an underpayment; Generated in conjunction with BI01X1.
Assistance Categories:	All
Hearing Rights:	Yes
Program ID:	GCU023
Transaction ID:	CU023
Frequency:	Daily
Volume (est. monthly):	9000
Form Number:	DHS 8510

Notes:

WCOW 1037

0003919

IMPORTANT NOTICE

GUERNSEY COUNTY DEPT OF HUMAN SERVICES
324 HIGHLAND AVE.

CAMBRIDGE OH 437250000

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 07/10/2000
From: CHRISTINA WALKER
Phone: (740) 432-2381 Ext:

Worker ID: WCOW30
Case Number: 9999999999
AG Name: JANE DOE

Dear JANE DOE

We have reviewed your case and approved more FOOD STAMPS for you.

FS 1 X1

You can get $229 more FOOD STAMPS for 06/01/2000 through 07/31/2000. You must add these food stamps to your Ohio Direction EBT Card by 07/31/2000.

WARNING! You will lose any food stamps that you fail to add to your Ohio Direction EBT Card by the deadline. After you add food stamps to your Card you may use them whenever you wish.

Contact your county Direction Card EBT office: to get your plastic Card; or to get help with your Card or PIN; or to report your Card is lost, stolen, or damaged. Call the Helpline (1-800-944-3273) to check your account balance; or to change the location where you add food stamps to your Card.

FS 1 X2

KEEP READING >>>

SEQ# 0013809 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0003919
ODS 8510 (Rev. 12/97) 9999999999/FS /01 NOTICE TYPE: BI01X1

AG Name:	Case Number:	Mailing Date:
JANE DOE	1000725448	07/10/2000

YOUR RIGHT TO A STATE HEARING

This notice is to tell you about action we are taking on your case. If you do not understand this action, you should contact your caseworker. After talking to your caseworker, it is possible that we will change our decision or that you will agree with the action.

IF YOU DO NOT AGREE WITH THIS ACTION, YOU HAVE A RIGHT TO A STATE HEARING.

A state hearing lets you or your representative (lawyer, welfare rights worker, friend or relative) give your reasons against the action. We will also attend the hearing to present our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

If you want a hearing we must receive your hearing request within 90 days of the mailing date on this notice.

If someone else makes a written hearing request for you, it must include a written statement, signed by you, telling us that person is your representative. Only you can make a request by telephone.

If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association, toll free at 1-(800)-589-5888, for the local number.

If you want a state hearing, check the appropriate box below, sign and date this form and send ALL PAGES to the Ohio Department of Human Services, State Hearings, 30 East Broad Street, 31st floor, Columbus, Ohio 43266-0423.

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

☐ I want a state hearing only.

I want a hearing.

SIGNATURE	DATE	TELEPHONE NUMBER

END

Client Notice: BI01-X5

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	December, 1997

Description of Notice:	Notice that underpayment will be used to offset existing underpayment; Generated in conjunction with BI01X1.
Assistance Categories:	All
Hearing Rights:	Yes
Program ID:	GCU023
Transaction ID:	CU023
Frequency:	Daily
Volume (est. monthly):	70
Form Number:	DHS 8510

Notes:

0000024 WLLK 2034

TUSCARAWAS COUNTY DEPT OF HUMAN SERVICES
247 STONECREEK RD NW

NEW PHILADELPHI OH 446636902

IMPORTANT NOTICE

JANE DOE
111 MAIN ST.

ANYWHERE, USA 11111-1111

Mailing Date: 05/13/1998
From: LILLIAN L KENNEDY
Phone: (330) 339-7791 Ext:

Worker ID: WLLK79
Case Number: 1111111111
AG Name: JANE DOE

Dear JANE DOE

It has also been determined that your assistance group has an outstanding overpayment in the amount of $32.00. This underpayment will be used to offset the existing overpayment. The adjustment leaves an overpayment balance of $.00.

NOTE: An underpayment may only be offset against a previous overpayment if:

1. No repayment agreement exists on the overpayment, or
2. A repayment agreement exists but the repayment account is more than 60 days delinquent, or
3. The assistance group requests the offset to clear all or part of an outstanding overpayment balance.

FS 3 X5

KEEP READING >>>

SEQ# 0025551 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000024
ODS 8510 (Rev. 12/97) 1111111111/FS /03 NOTICE TYPE: BI01X5

AG Name:	Case Number:	Mailing Date:
JANE DOE	1111111111	05/13/1998

YOUR RIGHT TO A STATE HEARING

This notice is to tell you about action we are taking on your case. If you do not understand this action, you should contact your caseworker. After talking to your caseworker, it is possible that we will change our decision or that you will agree with the action.

IF YOU DO NOT AGREE WITH THIS ACTION, YOU HAVE A RIGHT TO A STATE HEARING.

A state hearing lets you or your representative (lawyer, welfare rights worker, friend or relative) give your reasons against the action. We will also attend the hearing to present our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

If you want a hearing we must receive your hearing request within 90 days of the mailing date on this notice.

If someone else makes a written hearing request for you, it must include a written statement, signed by you, telling us that person is your representative. Only you can make a request by telephone.

If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association, toll free at 1-(800)-589-5888, for the local number.

If you want a state hearing, check the appropriate box below, sign and date this form and send ALL PAGES to the Ohio Department of Human Services, State Hearings, 30 East Broad Street, 31st floor, Columbus, Ohio 43266-0423.

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

☐ I want a state hearing only.

I want a hearing.

SIGNATURE	DATE	TELEPHONE NUMBER

END

Client Notice: BI02N1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number: 98068-27

Date Implemented: 10/15/98

Last Date Revised: 12/97

Description of Notice: The notice is a notification of an electronic deposit.

Assistance Group(s): **All**

Hearing Rights: No

Program ID: GBI003

Transaction ID:

Frequency: Monthly

Volume (est. monthly): 6500

Form Number: DHS 8500

Notes:

0000380 WVBV 0027

FAIRFIELD COUNTY DEPT OF HUMAN SERVICES
P.O. BOX 890

LANCASTER OH 431300000

IMPORTANT NOTICE

JOHN DOE
111 MAIN ST

ANYWHERE, OH 99999-9999

Mailing Date: 04/28/1999
From: VICKI B VAN METER
Phone: (000) 000-0000 Ext:

Worker ID: WVBV23
Case Number: 9999999999
AG Name: JANE DOE

Notice of Direct Deposit Payment

On 05/03/1999 the amount of $216.00 has been deposited in your account # 9999999999 at the BANK ONE COLUMBUS NA. The payment represents your OHIO WORKS FIRST (OWF) benefit payment for the month of May .

If you have any questions concerning this payment, please contact your worker at the telephone number listed above.

END

SEQ# 0021243 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000380
ODS 8512 (Rev. 12/97) 9999999999/ADCR/01 NOTICE TYPE: BI02N1

Client Notice: BV04-A1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	December, 1997

Description of Notice:	Repayment Summary; Payment was made as negotiated.
Assistance Categories:	ADC, FS, GA
Hearing Rights:	No
Program ID:	GBV015
Transaction ID:	N/A
Frequency:	Monthly
Volume (est. monthly):	9
Form Number:	DHS 8514

Notes:

WFAX 0000

IMPORTANT NOTICE

FRANKLIN COUNTY DEPT OF HUMAN SERVICES
80 E. SALTIN ST.

COLUMBUS OH 432150000

As of 06/01/1998 you have used 04 months of your initial 36 months of Ohio Works First benefit eligibility. If you continue to be eligible, you have 32 months remaining. After you have used up your 36 months, you might be eligible for additional months. See your caseworker.

JOHN DOE
111 MAIN ST.

ANYWWHERE, USA 11111-1111

Mailing Date: 06/02/1998
From: JOHN DOE
Phone: (301) 777-9311 Ext: 1111

Worker ID: WFAX00
Case Number: 3000000000
AG Name: JOHN DOE

Dear JOHN DOE

CLAIM NUMBER	TOTAL PAYMENTS FOR THE MONTH	BALANCE DUE
1000000065FS 0102	$5.00	$11,594.00

Thank you for your payment.

If you do not understand or have questions about this notice, please contact the worker named above.

END

SEQ# 0011500 THIS SPACE FOR OFFICIAL USE ONLY
ODS 8514 (Rev. 12/97) 3000000000/FS /01 NOTICE TYPE: BV04A1

Client Notice: BV04-A2

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	December, 1997

Description of Notice:	Repayment Summary; No payment was made. (Open AG)
Assistance Categories:	ADC, FS, GA
Hearing Rights:	No
Program ID:	GBV015
Transaction ID:	
Frequency:	Monthly
Volume (est. monthly):	5
Form Number:	DHS 8514
Notes:	GA was terminated 7/31/95.

WRDV 2663

0000001

IMPORTANT NOTICE

FRANKLIN CO COC COUNTY DEPT OF HUMAN SERVICES
314 N. WILSON RD.

COLUMBUS OH 432040000

JOHN DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 08/02/1999
From: RUTH D MILLER
Phone: (740) 385-5663 Ext:

Worker ID: WRDV37
Case Number: 9999999999
AG Name: JOHN DOE

Dear JOHN DOE

CLAIM NUMBER	TOTAL PAYMENTS FOR THE MONTH	BALANCE DUE
9999999999ADCR0104	$.00	$549.00

You have not paid as previously agreed. If you do not make a payment or contact the agency to discuss renegotiation of the payment schedule by 09/01/1999, without further notice we will subtract $65.00 each month from your OHIO WORKS FIRST (OWF) benefits for 9 month(s) beginning 10/01/1999. This represents 0.0% or $65.00 of your monthly benefit, whichever is greater.

If you do not understand or have questions about this notice, please contact the worker named above.

KEEP READING >>>

SEQ# 0006109 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000001
ODS 8514 (Rev. 12/97) 9999999999/ADCI/03 NOTICE TYPE: BV04A2

AG Name:	Case Number:	Mailing Date:
JOHN DOE	9999999999	08/02/1999

YOUR RIGHT TO A STATE HEARING

This notice is to tell you about action we are taking on your case. If you do not understand this action, you should contact your caseworker. After talking to your caseworker, it is possible that we will change our decision or that you will agree with the action.

IF YOU DO NOT AGREE WITH THIS ACTION, YOU HAVE A RIGHT TO A STATE HEARING. A state hearing lets you or your representative (lawyer, welfare rights worker, friend, or relative) give your reasons against the action. We will also attend the hearing to present our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

If you want a hearing, we must receive your hearing request within 90 days of the mailing date on this notice.

You do not need to return this form if you agree with the action. If we receive your request by 08/17/1999, the action will not be taken until the state hearing is decided. If you lose your hearing, you may have to pay back benefits that you were not eligible to receive.

If someone else makes a written hearing request for you, it must include a written statement, signed by you, telling us that person is your representative. Only you can make a request by telephone.

If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association toll free, at 1-800-589-5888, for the local number.

If you want a state hearing, check the appropriate box, sign and date this form, and send ALL PAGES to the Ohio Department of Human Services, Bureau of State Hearings, P.O. Box 182825, 31st Floor, Columbus, Ohio 43218-2825.

☐ I want a county conference and a state hearing.

☐ I want a state hearing only.

I want a state hearing.

SIGNATURE	DATE	TELEPHONE NUMBER

END

Client Notice: BV04-A3

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	December, 1997

Description of Notice:	Repayment Summary; No payment was made (closed AG).
Assistance Categories:	ADC, FS, GA
Hearing Rights:	No
Program ID:	GBV015
Transaction ID:	
Frequency:	Monthly
Volume (est. monthly):	25
Form Number:	DHS 8514
Notes:	The General Assistance program was terminated 7/31/95.

WFAX 0000

IMPORTANT NOTICE

FRANKLIN COUNTY DEPT OF HUMAN SERVICES
88 E. SALTIN ST.

COLUMBUS OH 432150000

As of 06/01/1998 you have used 04 months of your initial 36 months of Ohio Works First benefit eligibility. If you continue to be eligible, you have 32 months remaining. After you have used up your 36 months, you might be eligible for additional months. See your caseworker.

JOHN DOE
111 MAIN ST.

ANYWHERE, USA 11111-1111

Mailing Date: 06/02/1998
From: JOHN DOE
Phone: (301) 777-9311 Ext: 1111

Worker ID: WFAX00
Case Number: 5000000000
AG Name: JOHN DOE

Dear JOHN DOE

CLAIM NUMBER	TOTAL PAYMENTS FOR THE MONTH	BALANCE DUE
1000129690FS 0201	$.00	$201.00

You have not paid as previously agreed. You must contact us and explain why you could not make the payment. If you can no longer afford to pay the amount due, you may ask to pay less each month.

If you do not understand or have questions about this notice, please contact the worker named above.

END

SEQ# 0011700 THIS SPACE FOR OFFICIAL USE ONLY
ODS 8514 (Rev. 12/97) 5000000000/FS /02 NOTICE TYPE: BV04A3

Client Notice: BV04-A4

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	December, 1997

Description of Notice:	Repayment Summary; First partial payment (open FS AG - claim type IPV or IHE).
Assistance Categories:	open FS with claim type IPV or IHE
Hearing Rights:	No
Program ID:	GBV015
Transaction ID:	
Frequency:	Monthly
Volume (est. monthly):	25
Form Number:	DHS 8514
Notes:	

WMAM 2352

0000003

IMPORTANT NOTICE

MONTGOMERY COUNTY DEPT OF HUMAN SERVICES
1111 S. EDWIN C. MOSES BLV
P.O. BOX 972
DAYTON OH 454220000

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 08/02/1999
From: MAUDEAN MYERS
Phone: (937) 225-4798 Ext:

Worker ID: WMAM57
Case Number: 9999999999
AG Name: JANE DOE

Dear JANE DOE

CLAIM NUMBER	TOTAL PAYMENTS FOR THE MONTH	BALANCE DUE
9999999999FS 0102	$32.50	$4,399.50

Thank you for your payment.

You have not paid as previously agreed. If you do not make a payment or contact the agency to discuss renegotiation of the payment schedule by 09/01/1999, without further notice we will subtract $44.00 each month from your FOOD STAMPS benefits for 0 month(s) beginning 10/01/1999. This represents 20.0% or $44.00 of your monthly benefit, whichever is greater.

If you do not understand or have questions about this notice, please contact the worker named above.

KEEP READING >>>

AG Name:	Case Number:	Mailing Date:
JANE DOE	9999999999	08/02/1999

YOUR RIGHT TO A STATE HEARING

This notice is to tell you about action we are taking on your case. If you do not understand this action, you should contact your caseworker. After talking to your caseworker, it is possible that we will change our decision or that you will agree with the action.

IF YOU DO NOT AGREE WITH THIS ACTION, YOU HAVE A RIGHT TO A STATE HEARING. A state hearing lets you or your representative (lawyer, welfare rights worker, friend, or relative) give your reasons against the action. We will also attend the hearing to present our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

If you want a hearing, we must receive your hearing request within 90 days of the mailing date on this notice.

You do not need to return this form if you agree with the action. If we receive your request by 08/17/1999, the action will not be taken until the state hearing is decided. If you lose your hearing, you may have to pay back benefits that you were not eligible to receive.

If someone else makes a written hearing request for you, it must include a written statement, signed by you, telling us that person is your representative. Only you can make a request by telephone.

If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association toll free, at 1-800-589-5888, for the local number.

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

☐ I want a county conference and a state hearing.

☐ I want a state hearing only.

I want a state hearing.

SIGNATURE	DATE	TELEPHONE NUMBER

END

Client Notice: BV04-A5

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	December, 1997

Description of Notice:	Repayment Summary; First partial payment (closed FS with claim type IPV or IHE).
Assistance Categories:	(closed FS with claim type IPV or IHE).
Hearing Rights:	no
Program ID:	GBV015
Transaction ID:	
Frequency:	Monthly
Volume (est. monthly):	1
Form Number:	DHS 8514
Notes:	GA was teminated 7/31/95.

WFAX 2801

IMPORTANT NOTICE

LUCAS COUNTY DEPT OF HUMAN SERVICES
7460 CHERRY STREET
P.O. BOX 10007
TOLEDO OH 436990007

As of 06/01/1998 you have used 04 months of your initial 36 months of Ohio Works First benefit eligibility. If you continue to be eligible, you have 32 months remaining. After you have used up your 36 months, you might be eligible for additional months. See your caseworker.

JANE DOE
111 MAIN ST.

ANYWHERE, USA 11111-1111

Mailing Date: 06/02/1998
From: JOHN DOE
Phone: (301) 777-9311 Ext: 1111

Worker ID: WFAX00
Case Number: 7000000000
AG Name: JANE DOE

Dear JANE DOE

CLAIM NUMBER	TOTAL PAYMENTS FOR THE MONTH	BALANCE DUE
1000150720ADCR0102	$10.00	$269.00

Thank you for your payment.

You have not paid as previously agreed. You must contact us and explain why you could not make the payment. If you can no longer afford to pay the amount due, you may ask to pay less each month.

If you do not understand or have questions about this notice, please contact the worker named above.

END

SEQ# 0011900 THIS SPACE FOR OFFICIAL USE ONLY
ODS 8514 (Rev. 12/97) 7000000000/ADCR/01 NOTICE TYPE: BV04A5

Client Notice: BV04-A6

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	December, 1997

Description of Notice:	Repayment Summary; Second partial payment (open FS with claim type IPV or IHE)
Assistance Categories:	open FS with claim type IPV or IHE
Hearing Rights:	No
Program ID:	GBV015
Transaction ID:	N/A
Frequency:	Monthly
Volume (est. monthly):	17
Form Number:	DHS 8514
Notes:	

WLJT 7041

0000002

SUMMIT COUNTY DEPT OF HUMAN SERVICES
220 S. BALCH STREET

AKRON OH 443020000

IMPORTANT NOTICE

JOHN DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 08/02/1999
From: LINDA J THOMPSON
Phone: (330) 643-7298 Ext:

Worker ID: WLJT77
Case Number: 9999999999
AG Name: JOHN DOE

Dear JOHN DOE

CLAIM NUMBER	TOTAL PAYMENTS FOR THE MONTH	BALANCE DUE
9999999999FS 0103	$15.00	$274.00

Thank you for your payment.

You have not paid as previously agreed. If you do not make a payment or contact the agency to discuss renegotiation of the payment schedule by 09/01/1999, without further notice we will subtract $81.00 each month from your FOOD STAMPS benefits for 4 month(s) beginning 10/01/1999. This represents 20.0% or $81.00 of your monthly benefit, whichever is greater.

If you do not understand or have questions abount this notice, please contact the worker named above.

KEEP READING >>>

SEQ# 0006111 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000002
ODS 8514 (Rev. 12/97) 9999999999/FS /01 NOTICE TYPE: BV04A6

AG Name:	Case Number:	Mailing Date:
JOHN DOE	9999999999	08/02/1999

YOUR RIGHT TO A STATE HEARING

This notice is to tell you about action we are taking on your case. If you do not understand this action, you should contact your caseworker. After talking to your caseworker, it is possible that we will change our decision or that you will agree with the action.

IF YOU DO NOT AGREE WITH THIS ACTION, YOU HAVE A RIGHT TO A STATE HEARING. A state hearing lets you or your representative (lawyer, welfare rights worker, friend, or relative) give your reasons against the action. We will also attend the hearing to present our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

If you want a hearing, we must receive your hearing request within 90 days of the mailing date on this notice.

You do not need to return this form if you agree with the action. If we receive your request by 08/17/1999, the action will not be taken until the state hearing is decided. If you lose your hearing, you may have to pay back benefits that you were not eligible to receive.

If someone else makes a written hearing request for you, it must include a written statement, signed by you, telling us that person is your representative. Only you can make a request by telephone.

If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association toll free, at 1-800-589-5888, for the local number.

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

☐ I want a county conference and a state hearing.

☐ I want a state hearing only.

I want a state hearing.

SIGNATURE	DATE	TELEPHONE NUMBER

END

Client Notice: BV04-A7

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	December, 1997

Description of Notice:	Repayment Summary; Second partial payment [closed FS - claim type IPV or IHE; all ADC, GA]
Assistance Categories:	closed FS with claim type IPV or IHE; All ADC, GA
Hearing Rights:	No
Program ID:	GBV015
Transaction ID:	
Frequency:	Monthly
Volume (est. monthly):	350
Form Number:	DHS 8514
Notes:	The General Assistance preogram terminated 7/31/95

WFAX 2222

IMPORTANT NOTICE

ERIE COUNTY DEPT OF HUMAN SERVICES
871 W. PARISH ST.

SANDUSKY OH 448700000

As of 06/01/1998 you have used 04 months of your initial 36 months of Ohio Works First benefit eligibility. If you continue to be eligible, you have 32 months remaining. After you have used up your 36 months, you might be eligible for additional months. See your caseworker.

JANE DOE
111 MAIN ST.

ANYHERE, USA 11111-1111

Mailing Date: 06/02/1998
From: JOHN DOE
Phone: (301) 777-9311 Ext: 1111

Worker ID: WFAX00
Case Number: 9000000000
AG Name: JANE DOE

Dear JANE DOE

CLAIM NUMBER	TOTAL PAYMENTS FOR THE MONTH	BALANCE DUE
1000686210ADCR0101	$5.00	$225.00

Thank you for your payment.

You have not paid as previously agreed. You must contact us and explain why you could not make the payment. If you can no longer afford to pay the amount due, you may ask to pay less each month.

If you do not understand or have questions about this notice, please contact the worker named above.

END

SEQ# 0012100 THIS SPACE FOR OFFICIAL USE ONLY
ODS 8514 (Rev. 12/97) 9000000000/ADCR/01 NOTICE TYPE: BV04A7

Client Notice: BV05-O1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	December, 1997

Description of Notice:	Notice of medicaid overpayment
Assistance Categories:	All
Hearing Rights:	Yes
Program ID:	GBV002, GBV003
Transaction ID:	BVRC, BVCP
Frequency:	Daily
Volume (est. monthly):	95
Form Number:	DHS 8515

Notes:

WPJW 3038

0000001

IMPORTANT NOTICE

PICKAWAY COUNTY DEPT OF HUMAN SERVICES
110 ISLAND ROAD
P.O. BOX 439
CIRCLEVILLE OH 431130000

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 08/30/1999
From : PAMELA J WOOD S
Phone : (740) 474-7588 Ext:

Worker ID: WPJW65
Case Number :9999999999
AG Name : JANE DOE

DearJANE DOE

SECTION I: OVERPAYMENT

After a careful review, we have determined that from 10/01/1994 through 11/30/1997 your assistance group received $274.00 more in medical services paid by Medicaid than your assistance group was eligible to receive. You are responsible for repayment of the amount overpaid.

REASON FOR OVERPAYMENT

Reason: RECEIPT OF OR INCREASE IN UNEARNED INCOME
RC: 325
We based this action on OHIO ADMINISTRATIVE CODE, Rule 7436.

Claim number: 9999999999MA D0101

SECTION II: YOUR RESPONSIBILITY

You are responsible for repayment of the overpayment. You may repay the overpayment by choosing one of the repayment arrangements listed in Section III.

If you do not return this form with your choice of repayment arrangements by 09/29/1999, we may take legal action against you to recover the overpayment.

If you choose a repayment agreement and then find that the repayment is difficult or impossible, contact the county department of human services. We will review your present financial situation with you. If you and the county department of human services cannnot agree upon a repayment arrangement, you may stop repayment under your present repayment arrangement, but you are still responsibile for repayment of the overpayment. We may take legal action against you to recover the overpayment.

KEEP READING >>>

SECTION III: REPAYMENT ARRANGEMENTS

You may choose one of the repayment arrangements below:

LUMP-SUM REPAYMENT- The entire overpayment repaid in one payment prior to 09/29/1999. If you repay part of the overpayment in a lump-sum, you may repay the rest of the overpayment in monthly payments by completing the following Monthly Recovery Agreement section.

If you agree to make the entire payment prior to 09/29/1999, complete and sign your name below and return the form.

I agree to repay the entire overpayment in one lump-sum payment prior to 09/29/1999

SIGNATURE	DATE	TELEPHONE NUMBER

MONTHLY RECOVERY AGREEMENT - You agree to make an initial payment at once and the balance in monthly payments, or pay the entire overpayment in monthly payments until the overpayment is repaid.

If you choose to repay the overpayment in monthly payments, complete and sign your name below and return the form. If you and the county department of human services cannot agree upon the terms of a separate monthly recovery agreement, you are not bound by signing this form. If you wish to discuss terms, please contact your worker. You do remain responsible for repayment of the overpayment and we may take legal action against you to recover the overpayment.
I agree to repay $_____ no later than (date) _____ and to pay $_____ in monthly payments beginning (date) _____.

SIGNATURE	DATE	TELEPHONE NUMBER

AG Name:	Case Number:	Mailing Date:
JANE DOE	9999999999	08/30/1999

YOUR RIGHT TO A STATE HEARING

This notice is to tell you about action we are taking on your case. If you do not understand this action, you should contact your caseworker. After talking to your caseworker, it is possible that we will change our decision or that you will agree with the action.

IF YOU DO NOT AGREE WITH THIS ACTION, YOU HAVE A RIGHT TO A STATE HEARING. A state hearing lets you or your representative (lawyer, welfare rights worker, friend or relative) give your reasons against the action. We will also attend the hearing to present our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

If you want a hearing, we must receive your hearing request within 90 days of the mailing date on this notice.

If someone else makes a written hearing request for you, it must include a written statement, signed by you, telling us that person is your representative. Only you can make a request by telephone.

If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association toll free, at 1-(800)-589-5888, for the local number.

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

☐ I want a county conference and a state hearing.

☐ I want a state hearing only.

I want a state hearing.

SIGNATURE	DATE	TELEPHONE NUMBER

END

Client Notice: BV07-O1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	December, 1997

Description of Notice:	Notice of grant reduction to recoup overpayment.
Assistance Categories:	ADC, GA, DA
Hearing Rights:	Yes
Program ID:	GBV003
Transaction ID:	BVCP
Frequency:	Daily
Volume (est. monthly):	3000
Form Number:	DHS 8539
Notes:	The General Assistance was discontinued as of 7/31/95.

WMLP 2401

0000001

IMPORTANT NOTICE

MARION COUNTY DEPT OF HUMAN SERVICES
363 W. FAIRGROUND ST.
P.O. BOX 1817
MARION OH 433020000

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 06/14/1999
From: MARY L PERKINS
Phone: (740) 387-8560 Ext: 0268

Worker ID: WMLP51
Case Number: 9999999999
AG Name: JANE DOE

Dear JANE DOE

Please read this notice carefully. As previously notified, you have received an overpayment of benefits. After a review of your circumstances, we have determined the following:

Your OHIO WORKS FIRST (OWF) benefits will be **DECREASED** from $362.00 to $326.00 effective 08/01/1999.

The following individuals are affected by this action:

JOHN D (ELIGIBLE) JANE D (INELIGIBLE) JANE D (ELIGIBLE) JOHN D (ELIGIBLE)

REASON: INCREASE IN EARNED INCOME
We based this action on OHIO ADMINISTRATIVE CODE, Rule 5101:1-23-20.

RC: 317

Claim Numbers: 9999999999ADCI0102
9999999999ADCI0103
9999999999ADCI0104

KEEP READING >>>

SEQ# 0019010 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000001
ODS 8539 (Rev. 12/97) 9999999999/ADCR/03 NOTICE TYPE: BV07O1

AG Name:	Case Number:	Mailing Date:
JANE DOE	9999999999	06/14/1999

YOUR RIGHT TO A STATE HEARING

This notice is to tell you about action we are taking on your case. If you do not understand this action, you should contact your caseworker. After talking to your caseworker, it is possible that we will change our decision or that you will agree with the action.

IF YOU DO NOT AGREE WITH THIS ACTION, YOU HAVE A RIGHT TO A STATE HEARING. A state hearing lets you or your representative (lawyer, welfare rights worker, friend, or relative) give your reasons against the action. We will also attend the hearing to present our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

If you want a hearing, we must receive your hearing request within 90 days of the mailing date on this notice.

You do not need to return this form if you agree with the action. If we receive your request by **06/29/1999**, the action will not be taken until the state hearing is decided. If you lose your hearing, you may have to pay back benefits that you were not eligible to receive.

If someone else makes a written hearing request for you, it must include a written statement, signed by you, telling us that person is your representative. Only you can make a request by telephone.

If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association toll free, at 1-800-589-5888, for the local number.

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

☐ I want a county conference and a state hearing.

☐ I want a state hearing only.

I want a state hearing.

SIGNATURE	DATE	TELEPHONE NUMBER

END

Client Notice: BV12-O1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	December, 1997

Description of Notice:	Notice of ADC overpayment - open assistance groups only
Assistance Categories:	ADC
Hearing Rights:	Yes
Program ID:	GBV002, GBV003
Transaction ID:	BVRC, BVCP
Frequency:	Daily
Volume (est. monthly):	2227
Form Number:	DHS 8538
Notes:	This notice is generated when a worker enters a new claim for an ADC assistance group that has a status of 'O' (open) or 'S' (suspended) and a claim status of 'OA' (open awaiting). 'Open Awaiting' means that a claim is now open and is awaiting recipient

WGEB 0072

0000001

IMPORTANT NOTICE

HAMILTON COUNTY DEPT OF HUMAN SERVICES
222 E. CENTRAL PARKWAY

CINCINNATI OH 452020000

As of 05/18/1999 you have used 04 months of your initial 36 months of Ohio Works First benefit eligibility. If you continue to be eligible, you have 32 months remaining. After you have used up your 36 months, you might be eligible for additional months. See your caseworker.

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 05/19/1999
From: MRS. G BLACKWELL
Phone: (513) 946-1561 Ext:

Worker ID: WGEB31
Case Number: 9999999999
AG Name: JANE DOE

Dear JANE DOE

SECTION I: OVERPAYMENT

We have determined that, from 09/01/1993 through 12/31/1993, your assistance group received $1,116.00 more in OHIO WORKS FIRST (OWF) payments than you were eligible for. You are responsible for repayment of the amount of the overpayment.

REASON FOR OVERPAYMENT

REASON: INCREASE IN EARNED INCOME
RC: 317
We based this action on OHIO ADMINISTRATIVE CODE, Rule 5101:1-23-20.

Claim Number: 9999999999ADCR0102

SECTION II: YOUR RESPONSIBILITY

Your are responsible for repaying the overpayment. You may repay the overpayment by choosing any of the three repayment methods listed in Section III.

If you do not return this form with your choice of repayment arrangement by 06/18/1999, we may take one of the following actions: A) Reduce your OWF check until the overpayment is fully repaid or B) Take legal action against you to recover the overpayment.

If you choose a repayment agreement and then find that the repayment is difficult or impossible, contact us. If we cannot agree upon a repayment agreement, you may stop repayment under your present arrangement, but you will still be responsible for repayment of the overpayment. We may take one of the two actions (A or B) listed above.

KEEP READING >>>

SECTION III: REPAYMENT ARRANGEMENTS

INSTRUCTIONS: Read the description of the three repayment methods below. If you agree to repay the overpayment, check the block to indicate the method you choose, fill out and sign that section, and return ALL PAGES of this form to us.

☐ **LUMP-SUM REPAYMENT:** The entire overpayment is to be repaid in one payment within 60 days from the mailing date on this notice. If you repay part of the overpayment in a lump-sum, you may repay the rest in monthly payments by completing the Monthly Repayment Section below.

I agree to repay the entire overpayment in one lump-sum payment within 60 days.

SIGNATURE	DATE	TELEPHONE NUMBER

☐ **MONTHLY REPAYMENT AGREEMENT:** You agree to make an initial payment at once and the balance in monthly payments, or repay the entire overpayment in monthly payments, until the overpayment is repaid. The amount you repay each month cannot be more than the amount which would be recovered by grant reduction.

The signed repayment agreement is not a binding contract and can be renegotiated if necessary. If you wish to discuss terms, please contact the worker listed on page 1. If you fail to meet the terms of this agreement or terminate the agreement, you remain responsible for the repayment of any unpaid balance of the overpayment. We may take one of the actions listed in Section II to recover the full overpayment.

I agree to repay $_____ no later than (date) _____/_____/_____, and to pay $_____ in monthly payments beginning (date) _____/_____/_____.

SIGNATURE	DATE	TELEPHONE NUMBER

☐ **GRANT REDUCTION:** You agree to have your OWF check reduced each month until the overpayment is repaid. Your check may be reduced by up to 10% if you have no other income or liquid resources. If you have other income or liquid resources, your check may be reduced more, and may even be reduced to zero. Before your check is reduced, you will receive a written notice and will have an opportunity for a state hearing on it.

If you choose grant reduction, your monthly grant will be reduced by $29.00. This amount may change if the amount of your income or liquid assets changes.

8 **I agree to repay the overpayment by grant reduction. My OWF check will be reduced each month until the overpayment is repaid. If my OWF stops before the overpayment is repaid in full, I agree to negotiate a new repayment agreement.**

SIGNATURE	DATE	TELEPHONE NUMBER

KEEP READING >>>

AG Name:	Case Number:	Mailing Date:
JANE DOE	9999999999	05/19/1999

YOUR RIGHT TO A STATE HEARING

This notice is to tell you about action we are taking on your case. If you do not understand this action, you should contact your caseworker. After talking to your caseworker, it is possible that we will change our decision or that you will agree with the action.

IF YOU DO NOT AGREE WITH THIS ACTION, YOU HAVE A RIGHT TO A STATE HEARING. A state hearing lets you or your representative (lawyer, welfare rights worker, friend, or relative) give your reasons against the action. We will also attend the hearing to present our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

If you want a hearing, we must receive your hearing request within 90 days of the mailing date on this notice.

If someone else makes a written hearing request for you, it must include a written statement, signed by you, telling us that person is your representative. Only you can make a request by telephone.

If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association toll free, at 1-800-589-5888, for the local number.

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

☐ I want a county conference and a state hearing.

☐ I want a state hearing only.

I want a state hearing.

SIGNATURE	DATE	TELEPHONE NUMBER

END

Client Notice: BV13-O1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	December, 1997

Description of Notice:	Notice of ADC overpayment - closer assistance groups only.
Assistance Categories:	ADC
Hearing Rights:	Yes
Program ID:	GBV002, GBV003
Transaction ID:	BVRC, BVCP
Frequency:	Daily
Volume (est. monthly):	8400
Form Number:	DHS 8551
Notes:	This notice is generated when a worker enters a new claim for an ADC assistance group with a 'closed' status and a claim status of 'OA' (open awaiting). 'Open Awaiting' means that a claim is now open and is awaiting recipient response to the notice. Th

WBAS 0000

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IMPORTANT NOTICE

AUGLAIZE COUNTY DEPT OF HUMAN SERVICES
12 N. WOOD ST.
P.O. BOX 368
WAPAKONETA OH 458950000

JOHN DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 04/05/1999
From: BETH A SLIFE
Phone: (419) 738-7773 Ext:

Worker ID: WBAS06
Case Number: 9999999999
AG Name: JOHN DOE

SECTION I: OVERPAYMENT

We have determined that, from 09/01/1989 through 10/31/1989, your assistance group received $642.00 more in OHIO WORKS FIRST (OWF)payments than you were eligible for. You are responsible for repayment of the amount of the overpayment.

REASON FOR OVERPAYMENT

Reason: INCREASE IN EARNED INCOME
RC: 317
We based this action on OHIO ADMINISTRATIVE CODE, Rule 5101:1-23-20.

Claim Number: 9999999999ADCR0101

SECTION II: YOUR RESPONSIBILITY

You are responsible for repaying the overpayment. You may repay the overpayment by choosing either a lump-sum repayment or a monthly repayment agreement. These are explained in Section III.

If you do not return this form with your choice of repayment arrangement within 30 days from the mailing date on this notice, we may take legal action against you to recover the overpayment.

If you choose a repayment agreement and then find that the repayment is difficult or impossible, contact us. If we cannot agree upon a repayment arrangement, you may stop repayment under your present repayment arrangement, but you are still responsible for repayment of the overpayment. We may then take legal action against you to recover the overpayment.

KEEP READING >>>

SECTION III: REPAYMENT ARRANGEMENTS

Instructions: Read the description of the available repayment methods below. If you agree to repay the overpayment, check the block to indicate the method you choose, fill out and sign that section, and return ALL PAGES of the form to us.

☐ LUMP-SUM REPAYMENT - The entire overpayment is to be repaid in one payment within 60 days from the mailing date on this notice. If you repay part of the overpayment in a lump sum, you may repay the rest in monthly payments by completing the Monthly Repayment Section below.

I agree to repay the entire overpayment in one lump-sum payment within 60 days.		
SIGNATURE	DATE	TELEPHONE NUMBER

☐ MONTHLY REPAYMENT AGREEMENT - You agree to make an initial payment at once and the balance in monthly payments, or repay the entire overpayment in monthly payments, until the overpayment is repaid.

The signed repayment agreement is not a binding contract and can be renegotiated if necessary. If you wish to discuss terms, please contact your worker. If you fail to meet the terms of this agreement or terminate the agreement, you remain responsible for the repayment of any unpaid balance of the overpayment. We may take legal action to recover the full overpayment.

I agree to repay $_____ no later than (date) ____/____/____, and to pay $_____ in monthly payments beginning (date) ____/____/____.		
SIGNATURE	DATE	TELEPHONE NUMBER

KEEP READING >>>

AG Name:	Case Number:	Mailing Date:
JIMMIE M ROOP	5021173371	04/05/1999

YOUR RIGHT TO A STATE HEARING

This notice is to tell you about action we are taking on your case. If you do not understand this action, you should contact your caseworker. After talking to your caseworker, it is possible that we will change our decision or that you will agree with the action.

IF YOU DO NOT AGREE WITH THIS ACTION, YOU HAVE A RIGHT TO A STATE HEARING. A state hearing lets you or your representative (lawyer, welfare rights worker, friend or relative) give your reasons against the action. We will also attend the hearing to present our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

If you want a hearing, we must receive your hearing request within 90 days of the mailing date on this notice.

If someone else makes a written hearing request for you, it must include a written statement, signed by you, telling us that person is your representative. Only you can make a request by telephone.

If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association toll free, at 1-(800)-589-5888, for the local number.

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

☐ I want a county conference and a state hearing.

☐ I want a state hearing only.

I want a state hearing.

SIGNATURE	DATE	TELEPHONE NUMBER

END

Client Notice: BV15O1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number: N/A

Date Implemented: N/A

Last Date Revised: April, 2000

Description of Notice: Notice of ADC overpayment - only open assistance groups and ADC fraud sanctioned.

Assistance Group(s): ADC

Hearing Rights: YES

Program ID: GBV002, GBV003

Transaction ID: **BVRC, BVCP**

Frequency: Daily

Volume (est. monthly): 2000

Form Number: DHS 8538

Notes:

WMHM 2201

0000001

IMPORTANT NOTICE

JEFFERSON COUNTY DEPT OF HUMAN SERVICES
125 S. FIFTH ST.

STEUBENVILLE OH 439520000

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 03/17/1999
From: MARGARET H MONACO
Phone: (614) 282-0961 Ext: 0396

Worker ID: WMHM41
Case Number: 9999999999
AG Name: JANE DOE

Dear JANE DOE

SECTION I: OVERPAYMENT

We have determined that, from 02/01/1997 through 02/28/1997, your assistance group received $279.00 more in OHIO WORKS FIRST (OWF) than you were eligible to receive.

REASON FOR OVERPAYMENT

It has also been determined, through an administration disqualification hearing, a decision by a court of law, or because you signed an administrative disqualification hearing waiver or a disqualification consent agreement, that this overpayment was the result of an intentional program violation (fraud).

The determination of fraud has been made according to rules found in Chapter 5101:6-20 of the Ohio Administrative Code and Chapter 9000 of the Ohio Public Assistance Manual.
See Section IV for more information on how the determination of fraud will affect you and your assistance group.

Claim Number: 9999999999ADCU0101

SECTION II: YOUR RESPONSIBILITY

You are responsible for repaying this overpayment. You may repay it by choosing any of the three repayment methods listed in Section III.

If you do not return this form with your choice of repayment arrangement by 04/16/1999, we may take one of the following actions: A) Reduce your OWF check and apply the deduction to what you owe until the overpayment is fully repaid or B) Take legal action against you to recover the overpayment.

If you choose a repayment agreement and then find that the repayment is difficult or impossible, contact us. If we cannot agree upon a repayment plan, you may stop repayment under your present arrangement, but you will still be responsible for repayment of the overpayment. We may take one of the two actions (A or B) listed above to recover the overpayment.

KEEP READING >>>

SECTION III: REPAYMENT METHODS

INSTRUCTIONS: Read the description of the three repayment methods below. If you agree to repay the overpayment, check the block to indicate the method you choose, fill out and sign that section, and return ALL PAGES of this form to us.

☐ **LUMP-SUM REPAYMENT:** The entire overpayment is to be repaid in one payment within 60 days from the mailing date on this notice. If you repay part of the overpayment in a lump-sum, you may repay the rest in monthly payments by completing the Monthly Repayment Section below.

I agree to repay the entire overpayment in one lump-sum payment within 60 days.

SIGNATURE	DATE	TELEPHONE NUMBER

☐ **MONTHLY REPAYMENT AGREEMENT:** You agree to make an initial payment at once and the balance in monthly payments, or repay the entire overpayment in monthly payments, until the overpayment is repaid. The amount you repay each month cannot be more than the amount which would be recovered by grant reduction.

The signed repayment agreement is not a binding contract and can be renegotiated if necessary. If you wish to discuss terms, please contact the worker listed on Page 1. If you fail to meet the terms of this agreement or terminate the agreement, you remain responsible for the repayment of any unpaid balance of the overpayment. We may take one of the actions (A or B) listed in Section II to recover the full overpayment.

I agree to repay $_____ no later than (date) _____/_____/_____, and to pay $_____ in monthly payments beginning (date) _____/_____/_____.

SIGNATURE	DATE	TELEPHONE NUMBER

☐ **GRANT REDUCTION:** You agree to have your OWF check reduced each month until the overpayment is repaid. Your check may be reduced by up to 10% if you have no other income or liquid resources. If you have other income or liquid resources, your check may be reduced by more, and may even be reduced to zero. Before your check is reduced, you will receive a written notice and will have an opportunity for a state hearing on it.

If you choose grant reduction, your monthly grant will be reduced by $29.00. This amount may change if the amount of your income or liquid assets changes.

I agree to repay the overpayment by grant reduction. My OWF check will be reduced each month until the overpayment is repaid. If my OWF stops before the overpayment is repaid in full, I agree to negotiate a new repayment agreement.

SIGNATURE	DATE	TELEPHONE NUMBER

KEEP READING >>>

SECTION IV: FRAUD

Because this overpayment is the result of an intentional program violation (fraud), neither you nor the other members of your assistance group are eligible for OWF cash benefits until the overpayment has been repaid in full. You will get another notice, proposing to stop OWF for you and the other members of your assistance group, and giving you an opportunity for a state hearing on that action, before it happens.

AG Name:	Case Number:	Mailing Date:
JANE DOE	9999999999	03/17/1999

YOUR RIGHT TO A STATE HEARING

This notice is to tell you about action we are taking on your case. If you do not understand this action, you should contact your caseworker. After talking to your caseworker, it is possible that we will change our decision or that you will agree with the action.

IF YOU DO NOT AGREE WITH THIS ACTION, YOU HAVE A RIGHT TO A STATE HEARING. A state hearing lets you or your representative (lawyer, welfare rights worker, friend, or relative) give your reasons against the action. We will also attend the hearing to present our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

If you want a hearing, we must receive your hearing request within 90 days of the mailing date on this notice.

If someone else makes a written hearing request for you, it must include a written statement, signed by you, telling us that person is your representative. Only you can make a request by telephone.

If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association toll free, at 1-800-589-5888, for the local number.

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

☐ I want a county conference and a state hearing.

☐ I want a state hearing only.

I want a state hearing.

SIGNATURE	DATE	TELEPHONE NUMBER

END

Client Notice: BV16O1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number: N/A

Date Implemented: N/A

Last Date Revised: April, 2000

Description of Notice: Notice of ADC overpayment - only closed assistance groups and ADC fraud sanctioned.

Assistance Group(s): ADC

Hearing Rights: YES

Program ID: GBV002, GBV003

Transaction ID: **BVRC, BVCP**

Frequency: Daily

Volume (est. monthly): 2000

Form Number: DHS 8551

Notes:

WGRC 0000

0000002

IMPORTANT NOTICE

MONTGOMERY COUNTY DEPT OF HUMAN SERVICES
1111 S. EDWIN C. MOSES BLV
P.O. BOX 972
DAYTON OH 454220000

As of 03/16/1999 you have used 02 months of your initial 36 months of Ohio Works First benefit eligibility. If you continue to be eligible, you have 34 months remaining. After you have used up your 36 months, you might be eligible for additional months. See your caseworker.

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 03/17/1999
From: GEORGE R COSTNER
Phone: (937) 225-6471 Ext:

Worker ID: WGRC57
Case Number: 9999999999
AG Name: JANE DOE

Dear JANE DOE

SECTION I: OVERPAYMENT

We have determined that, from 11/13/1997 through 12/31/1997, your assistance group received $499.00 more in OHIO WORKS FIRST (OWF) than you were eligible to receive.

REASON FOR THE OVERPAYMENT:

It has also been determined, through an administration disqualification hearing, a decision by a court of law, or because you signed an administrative disqualification hearing waiver or a disqualification consent agreement, that this overpayment was the result of an intentional program violation (fraud).
The determination of fraud has been made according to rules found in Chapter 5101:6-20 of the Ohio Administrative Code and Chapter 9000 of the Ohio Public Assistance Manual.

See Section IV for more information on how the determination of fraud will affect you and your assistance group.

Claim Number: 9999999999ADCR0104

SECTION II: YOUR RESPONSIBILITY

You are responsible for repaying this overpayment. You may repay it by choosing either a lump-sum repayment or a monthly repayment agreement. These are explained in Section III.

If you do not return this form with your choice of repayment arrangement by 04/16/1999, we may take legal action against you to recover the overpayment.

If you choose a repayment agreement and then find that the repayment is difficult or impossible, contact us. If we cannot agree upon a repayment plan, you may stop repayment under your present arrangement, but you will still be responsible for repayment of the overpayment. We may then take legal action against you to recover the overpayment.

KEEP READING >>>

SECTION III: REPAYMENT METHODS

INSTRUCTIONS: Read the description of the two repayment methods below. If you agree to repay the overpayment, check the block to indicate the method you choose, fill out and sign that section, and return ALL PAGES of this form to us.

☐ **LUMP-SUM REPAYMENT:** The entire overpayment is to be repaid in one payment within 60 days from the mailing date on this notice. If you repay part of the overpayment in a lump-sum, you may repay the rest in monthly payments by completing the Monthly Repayment Section below.

I agree to repay the entire overpayment in one lump-sum payment within 60 days.

SIGNATURE	DATE	TELEPHONE NUMBER

☐ **MONTHLY REPAYMENT AGREEMENT:** You agree to make an initial payment at once and the balance in monthly payments, or repay the entire overpayment in monthly payments, until the overpayment is repaid.

The signed repayment agreement is not a binding contract and can be renegotiated if necessary. If you wish to discuss terms, please contact the worker listed on Page 1. If you fail to meet the terms of this agreement or terminate the agreement, you remain responsible for the repayment of any unpaid balance of the overpayment. We may take legal action to recover the full overpayment.

I agree to repay $_____ no later than (date) _____/_____/_____, and to pay $_____ in monthly payments beginning (date) _____/_____/_____.

SIGNATURE	DATE	TELEPHONE NUMBER

SECTION IV: FRAUD

Because this overpayment is the result of an intentional program violation (fraud), neither you nor the other members of your assistance group will be eligible for OWF cash benefits until the overpayment has been repaid in full.

KEEP READING >>>

AG Name:	Case Number:	Mailing Date:
JANE DOE	9999999999	03/17/1999

YOUR RIGHT TO A STATE HEARING

This notice is to tell you about action we are taking on your case. If you do not understand this action, you should contact your caseworker. After talking to your caseworker, it is possible that we will change our decision or that you will agree with the action.

IF YOU DO NOT AGREE WITH THIS ACTION, YOU HAVE THE RIGHT TO A STATE HEARING. A state hearing lets you or your representative (lawyer, welfare rights worker, friend, or relative) give your reasons against the action. We will also attend the hearing to present our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

If you want a hearing, we must receive your hearing request within 90 days of the mailing date on this notice.

If someone else makes a written hearing request for you, it must include a written statement, signed by you, telling us that person is your representative. Only you can make a request by telephone.

If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association toll free, at 1-800-589-5888, for the local number.

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

☐ I want a county conference and a state hearing.

☐ I want a state hearing only.

I want a state hearing.

SIGNATURE	DATE	TELEPHONE NUMBER

END

Client Notice: BV20-O1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	December, 1997

Description of Notice:	Notice of General Assistance Overpayment; Open assistance Groups only.
Assistance Categories:	GA, DA
Hearing Rights:	Yes
Program ID:	GBV002, GBV003
Transaction ID:	BVRC, BVCP
Frequency:	Daily
Volume (est. monthly):	200
Form Number:	DHS 8552
Notes:	GA ended 7/31/95.

WNJH 3030

0000001

IMPORTANT NOTICE

PUTNAM COUNTY DEPT OF HUMAN SERVICES
1225 EAST THIRD ST

OTTAWA OH 458750000

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 05/25/1999
From: NANCY J HUGHES
Phone: (419) 523-4580 Ext: 0124

Worker ID: WNJH69
Case Number: 9999999999
AG Name: JANE DOE

Dear JANE DOE

After a careful review, we have determined that from 05/01/1998 through 10/31/1998, your assistance group received $690.00 more in DISABILITY ASSISTANCE (DA) payments than your assistance group was eligible to receive.

REASON FOR OVERPAYMENT

REASON: RECEIPT OF OR INCREASE IN UNEMPLOYMENT COMPENSATION BENEFITS
RC: 420
We based this action on OHIO ADMINISTRATIVE CODE, Rule 5101:1-5-40.

Claim Number: 9999999999GA A0201

Please call your benefit recovery worker listed above by 6/24/1999 to schedule an appointment to choose a repayment agreement that best suits your situation. At the time of your appointment, please bring in all verification of current income and resources (e.g. car title, checking and savings accounts, certificates of deposit, bonds etc.). These verifications are needed to determine your current ability to repay.

Note: The county department of human services will not recover overpayments resulting from administrative error when ALL of the following conditions exist:

(1) You met all of your reporting responsibilities and did nothing to cause the overpayment.
(2) You were not aware of the error or overpayment and did not have any information which should have made you aware of the error or put you on notice of the error.
(3) You have not received notice of the error.
(4) You relied upon your honest belief that you were entitled to the payment.

KEEP READING >>>

SEQ# 0014420 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000001
ODS 8552 (Rev. 12/97) 9999999999/GA A/02 NOTICE TYPE: BV20O1

AG Name:	Case Number:	Mailing Date:
JANE DOE	9999999999	05/25/1999

YOUR RIGHT TO A STATE HEARING

This notice is to tell you about action we are taking on your case. If you do not understand this action, you should contact your caseworker. After talking to your caseworker, it is possible that we will change our decision or that you will agree with the action.

IF YOU DO NOT AGREE WITH THIS ACTION, YOU HAVE A RIGHT TO A STATE HEARING. A state hearing lets you or your representative (lawyer, welfare rights worker, friend, or relative) give your reasons against the action. We will also attend the hearing to present our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

If you want a hearing, we must receive your hearing request within 90 days of the mailing date on this notice.

If someone else makes a written hearing request for you, it must include a written statement, signed by you, telling us that person is your representative. Only you can make a request by telephone.

If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association toll free, at 1-800-589-5888, for the local number.

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

☐ I want a county conference and a state hearing.

☐ I want a state hearing only.

I want a state hearing.

SIGNATURE	DATE	TELEPHONE NUMBER

END

Client Notice: BV21-O1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	December, 1997

Description of Notice:	Notice of General Assistance overpayment; Closed Assistance Groups.
Assistance Categories:	GA, DA
Hearing Rights:	Yes
Program ID:	GBV002, GBV003
Transaction ID:	BVRC, BVCP
Frequency:	Daily
Volume (est. monthly):	1400
Form Number:	DHS 8540
Notes:	GA was terminated 7/31/95.

WLRL 0000

0000001

IMPORTANT NOTICE

LICKING COUNTY DEPT OF HUMAN SERVICES
P.O. BOX 5030

NEWARK OH 430585030

JOHN DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 05/19/1999
From: LAWANA R LANNING
Phone: (740) 349-6395 Ext:

Worker ID: WLRL45
Case Number: 9999999999
AG Name: JOHN DOE

Dear JOHN DOE

SECTION I: OVERPAYMENT

After a careful review, we have determined that from 08/01/1995 through 08/31/1995, your assistance group received $115.00 more in DISABILITY ASSISTANCE (DA) payments than your assistance group was eligible to receive.

REASON FOR OVERPAYMENT

REASON: NOT IN A DA CASH-COVERED GROUP
RC: 525
We based this action on OHIO ADMINISTRATIVE CODE, Rule 5101:1-5-01.

Claim Number: 9999999999GA A0203

SECTION II: YOUR RESPONSIBILITY

You are responsible for repayment of the overpayment. You may repay the overpayment by choosing either the lump-sum repayment or monthly repayment agreement listed in Section III.

If you choose a repayment agreement and then find that the repayment is difficult or impossible, contact the county department of human services. If you and the county department of human services cannot agree upon a repayment arrangement, you may stop repayment under your present repayment arrangement, but you are still responsible for repayment of the overpayment. We may take legal action to recover the overpayment.

KEEP READING >>>

SECTION III: REPAYMENT ARRANGEMENTS

Please check the following box beside the repayment arrangement that best suits your situation.

☐ Lump-Sum Repayment

☐ Monthly Repayment Agreement

LUMP-SUM REPAYMENT - The entire overpayment is to be repaid in one payment within 60 days from the date this form was sent by the county department of human services. If you repay part of the overpayment in a lump-sum, you may repay the rest of the overpayment in monthly payments by completing the following monthly repayment agreement section.

If you agree to make the entire payment within 60 days, complete and sign your name below and return the form.

I agree to repay the entire overpayment in one lump-sum payment within 60 days.		
SIGNATURE	DATE	TELEPHONE NUMBER

MONTHLY REPAYMENT AGREEMENT - You agree to make an initial payment at once and the balance in monthly payments, or repay the entire overpayment in monthly payments until the overpayment is repaid.

If you voluntarily choose to repay the overpayment in monthly payments, complete the following agreement, sign your name and return the form. The signed repayment agreement is not a binding contract and can be renegotiated if necessary. If you wish to discuss these terms, please contact the worker listed above. If you fail to meet the terms of this agreement or terminate the agreement, you remain responsible for the repayment of any of the unpaid balance of the overpayment. We may take legal action to recover the full overpayment.

I agree to repay $_____ no later than (date) _____/_____/_____, and to pay $_____ in payments beginning (date) _____/_____/_____.		
SIGNATURE	DATE	TELEPHONE NUMBER

INSTRUCTIONS

If you have agreed to repay the overpayment by choosing one of the repayment agreements, return this notice to the county department of human services.

AG Name:	Case Number:	Mailing Date:
JOHN DOE	9999999999	05/19/1999

YOUR RIGHT TO A STATE HEARING

This notice is to tell you about action we are taking on your case. If you do not understand this action, you should contact your caseworker. After talking to your caseworker, it is possible that we will change our decision or that you will agree with the action.

IF YOU DO NOT AGREE WITH THIS ACTION, YOU HAVE A RIGHT TO A STATE HEARING. A state hearing lets you or your representative (lawyer, welfare rights worker, friend, or relative) give your reasons against the action. We will also attend the hearing to present our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

If you want a hearing, we must receive your hearing request within 90 days of the mailing date on this notice.

If someone else makes a written hearing request for you, it must include a written statement, signed by you, telling us that person is your representative. Only you can make a request by telephone.

If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association toll free, at 1-800-589-5888, for the local number.

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

☐ I want a county conference and a state hearing.

☐ I want a state hearing only.

I want a state hearing.

SIGNATURE	DATE	TELEPHONE NUMBER

END

Client Notice: BV30-O1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	December, 1997

Description of Notice:	Notice of Food Stamp overpayment; Open assistance groups administrative error claims.
Assistance Categories:	FS
Hearing Rights:	Yes
Program ID:	GBV002, GBV003
Transaction ID:	BVRC, BVCP
Frequency:	Daily
Volume (est. monthly):	1000
Form Number:	DHS 8553
Notes:	

WGEB 0071

0000001

IMPORTANT NOTICE

HAMILTON COUNTY DEPT OF HUMAN SERVICES
222 E. CENTRAL PARKWAY

CINCINNATI OH 452020000

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 05/19/1999
From: MRS. G BLACKWELL
Phone: (513) 946-1561 Ext:

Worker ID: WGEB31
Case Number: 9999999999
AG Name: JANE DOE

Dear JANE DOE

After a careful review, we have determined that from 11/01/1998 through 11/30/1998, your assistance group received $335.00 more in FOOD STAMPS than you were eligible to receive.

REASON FOR OVERISSUANCE

REASON: INCREASE IN EARNED INCOME
RC: 317
We based this action on OHIO ADMINISTRATIVE CODE, Rule 5101:4-4-19.

Claim Number: 9999999999FS 0104

We have also determined that this overissuance was caused by an administrative error.

You must repay extra Food Stamps. Check one of the repayment agreements explained below, sign and date this form and send it to the address listed above. If your situation changes after you have signed the agreement, you have the right to renegotiate the repayment schedule. If you do not agree to repay the amount you owe, or if you agree to repay and fail to make payment, further appropriate action will be taken to collect the overissuance. If necessary, we will contact you to discuss your chosen method of repayment and confirm the amount and duration of monthly payments.

Failure to complete one of the repayment agreements below and return this form by 06/18/1999 will result in a reduction of $34.00 each month from your assistance group's food stamp allotment for 10 month(s) beginning 07/01/1999. This represents 10.0% or $10.00 of the monthly allotment, whichever is greater.

KEEP READING >>>

Repayment agreement (Check one).

- [ ] I agree to repay the entire amount of the claim in cash or coupons at this time.
- [ ] I agree to repay $_____ on the claim now and pay $_____ in monthly payments beginning next month.
- [ ] I agree to have $34.00 subtracted automatically each month from my household's Food Stamp allotment for 10 month(s) beginning 07/01/1999.

SIGNATURE	DATE	TELEPHONE NUMBER

AG Name:	Case Number:	Mailing Date:
jane doe	9999999999	05/19/1999

YOUR RIGHT TO A STATE HEARING

This notice is to tell you about action we are taking on your case. If you do not understand this action, you should contact your caseworker. After talking to your caseworker, it is possible that we will change our decision or that you will agree with the action.

IF YOU DO NOT AGREE WITH THIS ACTION, YOU HAVE A RIGHT TO A STATE HEARING. A state hearing lets you or your representative (lawyer, welfare rights worker, friend, or relative) give your reasons against the action. We will also attend the hearing to present our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

If you want a hearing, we must receive your hearing request within 90 days of the mailing date on this notice.

You do not need to return this form if you agree with the action. If we receive your request by **06/18/1999**, the action will not be taken until the state hearing is decided. If you lose your hearing, you may have to pay back benefits that you were not eligible to receive.

If someone else makes a written hearing request for you, it must include a written statement, signed by you, telling us that person is your representative. Only you can make a request by telephone.

If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association toll free, at 1-800-589-5888, for the local number.

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

☐ I want a county conference and a state hearing.

☐ I want a state hearing only.

I want a state hearing.

SIGNATURE	DATE	TELEPHONE NUMBER

END

Client Notice: BV31-O1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	December, 1997

Description of Notice:	Notice of Food Stamp overpayment. Closed Assistance Groups. All claim types.
Assistance Categories:	FS
Hearing Rights:	Yes
Program ID:	GBV002, GBV003
Transaction ID:	BVRC, BVCP
Frequency:	Daily
Volume (est. monthly):	4000
Form Number:	DHS 8554
Notes:	

WCLP 0000

0000001

IMPORTANT NOTICE

PORTAGE COUNTY DEPT OF HUMAN SERVICES
449 S. MERIDIAN ST.,2ND FL
P.O. BOX 1208
RAVENNA OH 442660000

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 05/19/1999
From: CAROL L PAULEY
Phone: (330) 297-3750 Ext: 3823

Worker ID: WCLP67
Case Number: 9999999999
AG Name: JANE DOE

Dear JANE DOE

After a careful review, we have determined that from 03/01/1995 through 04/30/1995, your assistance group received $348.00 more in FOOD STAMPS than you were eligible to receive.

REASON FOR OVERISSUANCE

REASON: INCREASE IN EARNED INCOME
RC: 317
We based this action on OHIO ADMINISTRATIVE CODE, Rule 5101:4-4-19.

Claim Number: 9999999999FS 0101

We have also determined that this overissuance was caused either by an administrative error, an inadvertent household error, or by an intentional misrepresentation of your situation or an intentional program violation.

You must repay extra Food Stamps even if you are not now receiving Food Stamps. Check one of the repayment agreements explained below, sign and date this form, and send it to the address listed above. If your situation changes after you have signed the agreement, you have the right to renegotiate the repayment schedule. If you do not agree to repay the amount you owe, or if you agree to repay and fail to make payment, further appropriate action will be taken to collect the overissuance. If necessary, we will contact you to discuss your chosen method of repayment and confirm the amount and duration of monthly payments.

KEEP READING >>>

SEQ# 0015257 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000001
ODS 8554 (Rev. 12/97) 9999999999/FS /01 NOTICE TYPE: BV31O1

Repayment agreement (Check one).

☐ I agree to repay the entire amount of the claim in cash at this time.

☐ I agree to repay $_____ on the claim now and pay $_____ in monthly payments beginning next month.

SIGNATURE	DATE	TELEPHONE NUMBER

AG Name:	Case Number:	Mailing Date:
JANE DOE	9999999999	05/19/1999

YOUR RIGHT TO A STATE HEARING

This notice is to tell you about action we are taking on your case. If you do not understand this action, you should contact your caseworker. After talking to your caseworker, it is possible that we will change our decision or that you will agree with the action.

IF YOU DO NOT AGREE WITH THIS ACTION, YOU HAVE A RIGHT TO A STATE HEARING. A state hearing lets you or your representative (lawyer, welfare rights worker, friend, or relative) give your reasons against the action. We will also attend the hearing to present our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

If you want a hearing, we must receive your hearing request within 90 days of the mailing date on this notice.

If someone else makes a written hearing request for you, it must include a written statement, signed by you, telling us that person is your representative. Only you can make a request by telephone.

If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association toll free, at 1-800-589-5888, for the local number.

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

☐ I want a county conference and a state hearing.

☐ I want a state hearing only.

I want a state hearing.

SIGNATURE	DATE	TELEPHONE NUMBER

END

Client Notice: BV32-O1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	December, 1997

Description of Notice:	Notice of Food Stamp overpayment. Open Assistance Groups, 'IPV' or 'IHE' claims.
Assistance Categories:	FS
Hearing Rights:	Yes
Program ID:	GBV002, GBV003
Transaction ID:	BVRC, BVCP
Frequency:	Daily
Volume (est. monthly):	1500
Form Number:	DHS 8555
Notes:	

WGEB 0072

0000001

IMPORTANT NOTICE

HAMILTON COUNTY DEPT OF HUMAN SERVICES
222 E. CENTRAL PARKWAY

CINCINNATI OH 452020000

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 05/19/1999
From: MRS. G BLACKWELL
Phone: (513) 946-1561 Ext:

Worker ID: WGEB31
Case Number: 9999999999
AG Name: JANE DOE

Dear JANE DOE

After a careful review, we have determined that from 04/01/1994 through 04/30/1994, your assistance group received $126.00 more in FOOD STAMPS than you were eligible to receive.

REASON FOR OVERISSUANCE

REASON: INCREASE IN EARNED INCOME
RC: 317
We based this action on OHIO ADMINISTRATIVE CODE, Rule 5101:4-4-19.

Claim Number: 9999999999FS 0102

We have also determined that this overissuance was caused either by an inadavertent household error or by an intentional misrepresentation of your situation or an intentional program violation.

Failure to complete one of the repayment agreements below and return this form by 06/18/1999 will result in a reduction of $23.00 each month from your assistance group's food stamp allotment for 5 month(s) beginning 07/01/1999. This represents 10.0% or $10.00 of the monthly allotment, whichever is greater.

You must repay extra Food Stamps. Check one of the repayment agreements explained below, sign and date this form and send it to the address listed above. If your situation changes after you have signed the agreement, you have the right to renegotiate the repayment schedule. If you do not agree to repay the amount you owe, or if you agree to repay and fail to make payment, further appropriate action will be taken to collect the overissuance. If necessary, we will contact you to discuss your chosen method of repayment and confirm the amount and duration of monthly payments.

KEEP READING >>>

Repayment agreement (Check one).

- [ ] I agree to repay the entire amount of the claim in cash or coupons at this time.
- [ ] I agree to repay $_____ on the claim now and pay $_____ in monthly payments beginning next month.
- [ ] I agree to have $23.00 subtracted automatically each month from my household's Food Stamp allotment for 5 month(s) beginning 07/01/1999.

SIGNATURE	DATE	TELEPHONE NUMBER

AG Name:	Case Number:	Mailing Date:
JANE DOE	9999999999	05/19/1999

YOUR RIGHT TO A STATE HEARING

This notice is to tell you about action we are taking on your case. If you do not understand this action, you should contact your caseworker. After talking to your caseworker, it is possible that we will change our decision or that you will agree with the action.

IF YOU DO NOT AGREE WITH THIS ACTION, YOU HAVE A RIGHT TO A STATE HEARING. A state hearing lets you or your representative (lawyer, welfare rights worker, friend, or relative) give your reasons against the action. We will also attend the hearing to present our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

If you want a hearing, we must receive your hearing request within 90 days of the mailing date on this notice.

You do not need to return this form if you agree with the action. If we receive your request by **06/18/1999**, the action will not be taken until the state hearing is decided. If you lose your hearing, you may have to pay back benefits that you were not eligible to receive.

If someone else makes a written hearing request for you, it must include a written statement, signed by you, telling us that person is your representative. Only you can make a request by telephone.

If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association toll free, at 1-800-589-5888, for the local number.

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

☐ I want a county conference and a state hearing.

☐ I want a state hearing only.

I want a state hearing.

SIGNATURE	DATE	TELEPHONE NUMBER

END

Client Notice: BV33O1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number: N/A

Date Implemented: N/A

Last Date Revised: April, 2000

Description of Notice: Notice of ADC or FS overpayment for claims with a work allowance violation type.

Assistance Group(s): **ADC, FS**

Hearing Rights: YES

Program ID: GBV002, Gbv003

Transaction ID: **BVRC, BVCP**

Frequency: Daily

Volume (est. monthly): 500

Form Number: DHS 8556

Notes:

WSAW 0000

0000001

IMPORTANT NOTICE

MEIGS COUNTY DEPT OF HUMAN SERVICES
P.O. BOX 191
175 RACE STREET
MIDDLEPORT OH 457600191

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 03/17/1999
From: SHIRLEY A WISE
Phone: (614) 992-2117 Ext: 0335

Worker ID: WSAW53
Case Number: 9999999999
AG Name: JANE DOE

Dear JANE DOE

We have determined that from 04/01/1996 through 04/30/1996, your assistance group received $25.00 more for the work allowance than you were eligible to receive.

REASON FOR OVERISSUANCE

REASON: FAILED/REFUSED TO PARTICIPATE IN WEP AS ASSIGNED
RC: 435
We based this action on OHIO REVISED CODE, Section .

Claim Number: 9999999999ADCR0203

You are responsible for repaying this overpayment, even if you are not now receiving benefits. Check one of the repayment methods explained on the next page, fill in your signature and the date, and return this form to us at the address above. If your economic situation changes after you have signed the agreement, you can renegotiate the repayment schedule. If you do not agree to repay the amount you owe, or if you agree to repay and fail to make payment, we may take further appropiate action to collect the overpayment. If necessary, we will contact you to discuss your chosen method of repayment and confirm the amount and duration of monthly payments.

KEEP READING >>>

Repayment agreement (Check one).

☐ I agree to repay the entire amount of the overpayment at this time.

☐ I agree to repay $_____ on the overpayment now and pay $_____ in monthly payments beginning next month.

SIGNATURE	DATE	TELEPHONE NUMBER

AG Name:	Case Number:	Mailing Date:
JANE DOE	9999999999	03/17/1999

YOUR RIGHT TO A STATE HEARING

This notice is to tell you about action we are taking on your case. If you do not understand this action, you should contact your caseworker. After talking to your caseworker, it is possible that we will change our decision or that you will agree with the action.

IF YOU DO NOT AGREE WITH THIS ACTION, YOU HAVE A RIGHT TO A STATE HEARING. A state hearing lets you or your representative (lawyer, welfare rights worker, friend, or relative) give your reasons against the action. We will also attend the hearing to present our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

If you want a hearing, we must receive your hearing request within 90 days of the mailing date on this notice.

If someone else makes a written hearing request for you, it must include a written statement, signed by you, telling us that person is your representative. Only you can make a request by telephone.

If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association toll free, at 1-800-589-5888, for the local number.

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

☐ I want a county conference and a state hearing.

☐ I want a state hearing only.

I want a state hearing.

SIGNATURE	DATE	TELEPHONE NUMBER

END

Client Notice: BV60-A1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	93286-01
Date Implemented:	09/22/1995
Last Date Revised:	September, 1997

Description of Notice:	60 Day Tax Offset Notice. This notice indicates the intent of the state to refer client for Federal Tax Offset.
Assistance Categories:	FS
Hearing Rights:	No
Program ID:	GBV233
Transaction ID:	N/A
Frequency:	Daily
Volume (est. monthly):	
Form Number:	ODHS 7900
Notes:	

0000001

ASHLAND COUNTY DHS
15 WEST FOURTH STREET

ASHLAND OH 44805-0000

IMPORTANT NOTICE

TO: JOHN DOE
111 MAIN ST.

ANYWHERE OH 99999-9999

Mailing Date: 08/18/1998

Social Security Number 999-99-99990

You have not paid the amount you owe to the Department of Human Services. If you do not pay your debt or take other actions described below before 60 days from the date of this letter, we will submit your debt to the Treasury Offset Program. We will add collection processing fees to your unpaid debt. We previously mailed or otherwise delivered a demand letter notifying you about the debt, including the right to a fair hearing, and have made other required collection efforts. Listed below is the debt we are attempting to collect.

Claim Number	Claim Period	Balance
9999999999/FS /01/01	08/91 - 09/91	$467.00
	TOTAL	$467.00

TREASURY OFFSET PROGRAM (TOP): Once your debt is submitted to the TOP, the U.S. Department of the Treasury (U.S. Treasury) will reduce or withhold any of your eligible Federal payments by the amount of your debt. This process, known as "offset", is authorized by the Debt Collection Act of 1982 and the Debt Collection Improvement Act of 1996. U. S. Treasury is not required to send you notice before your payment is offset. Federal payments eligible for offset include:

* your Federal income tax refunds;
* your Federal salary pay, including military pay;
* your Federal retirement, including military pay;
* your contractor/vendor payments
* certain Federal benefit payments, such as Social Security, Railroad Retirement (other than tier 2), and Black Lung (part B) benefits; and
* other Federal payments, including certain loans to you, that are not exempt from offset.

Before we submit your debt to the TOP, you may, (1) inspect and copy our records related to your debt; (2) request a review of our determination that you owe this debt; and, (3) enter into an acceptable written repayment agreement.

KEEP READING >>>>

TO AVOID THE TOP: You must do one of the following by 60 days from the mailing date of this letter:

REPAY YOUR DEBT: To repay your debt or to talk about it or to ask questions about this letter, call or write to:

		ASHLAND COUNTY DHS
Phone:	1-800-589-8141	15 WEST FOURTH STREET
Local:	419-289-8141	
		ASHLAND OH 44805-0000

If you come to the county department of human services to pay the debt, you should bring this letter with you.

AGREE TO A REPAYMENT PLAN: Acceptable repayment arrangements are as follows:

* If the total of the above-listed debt is $500 or less, you must pay it in full within 60 days of the mailing date of this notice.

* If the total of the above-listed debt is more than $500, you must, within 60 days of the mailing date of this notice, pay $500 and sign an agreement to repay the balance in regular payments.

REQUEST A REVIEW IF YOU BELIEVE THE DEBT IS NOT OWED: If you believe that all or part of the debt is not past due or is not legally enforceable, you can request a review by writing to the above address. You must send evidence to support your position and you must include your Social Security Number. If someone else makes a written request for a review for you, it must include a statement, signed by you, telling us that person is your representative. You will be informed of our decision about your debt.

BANKRUPTCY: If you filed for bankruptcy and the automatic bankruptcy stay is in effect, you are not subject to offset while the stay is in effect. Please notify us of the stay by sending evidence concerning the bankruptcy.

If you make or provide any knowingly false or frivolous statements, representations, or evidence, you may be liable for penalties under the False Claims Act (31 U.S.C. 3729-3731), or other applicable statutes, and/or criminal penalties under 18 U.S.C. 286, 287, 1001, and 1002, or other applicable statutes.

Unless prohibited by law or contract, we will promptly refund to you any amounts paid by you or deducted from your payment for your debt which are waived or found not owed.

IF YOU FILE A JOINT INCOME TAX RETURN: If you file a joint income tax return, you should contact the Internal Revenue Service before filing your return regarding the steps to take to protect the share of the income tax refund which may be payable to your spouse who is not a delinquent debtor to the U. S. Government.

IF YOU ARE A FEDERAL EMPLOYEE: Your current disposable pay is subject to offset if you do not pay your debt or take other action described above. Under the TOP, the U. S. Treasury will deduct up to 15% of your disposable net pay beginning in the pay period that your debt is submitted to the TOP, and continuing every pay period until your debt, including penalties and other costs, is paid in full.

If you make or provide any knowingly false or frivolous statements, representations, or evidence, in addition to other penalties, you may be subject to disciplinary actions.

Este aviso es para informarle que vamos a embargar su reembolso de impuestos federales sobre ingreso. Esta acción es para recuperar un pago en exceso de estampillas de comida. Si quiera recibir una copia de este aviso en español favor de enviar copia de este aviso y escriba a ASHLAND COUNTY DHS, 15 WEST FOURTH STREET, , ASHLAND, OH 44805-0000.

END

Client Notice: BV61-A1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	93286-01
Date Implemented:	09/22/1995
Last Date Revised:	September, 1997

Description of Notice:	Offset Notice - Indicates a collection and the status of outstanding claims.
Assistance Categories:	FS
Hearing Rights:	No
Program ID:	GVB233
Transaction ID:	N/A
Frequency:	Daily
Volume (est. monthly):	
Form Number:	ODHS 7901
Notes:	

0000001

COLUMBIANA COUNTY DHS
P.O. BOX 9

LISBON OH 44432-0000

IMPORTANT NOTICE

TO: JOHN DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 10/30/1998

Social Security number: 999-99-9999

We have recently collected $55.84 on a debt you owed us because you had received overpaid food stamp benefits. This collection was made under the authority of the Treasury Offset Program. It may have been recovered in a single collection or in a series of collections. The above amount has been applied to your food stamp debt. The balance and the status of this debt are as follows:

Claim Number	Overpayment Period	Balance	Status
9999999999/FS /01/01	03/92 - 05/92	$413.16	OPEN
	TOTAL	$413.16	

The federal agency which made the collection may also have advised you of the amount it collected. The amount collected may be greater than the amount stated in this notice. If so, the difference is due to an administrative fee for that collection.

The amount of the administrative fee you paid does not reduce the amount you owe for overpaid food stamp benefits.

You still owe us any remaining balance on this debt. You may also have other debts to the department which were not referred to the Treasury Offset Program. We still intend to collect these debts. To arrange to pay these debts or to talk about them, please contact the county department of human services.

Este aviso es para informarle que vamos a embargar su reembolso de impuestos federales sobre ingreso. Esta acción es para recuperar un pago en exceso de estampillas de comida. Si quiera recibir una copia de este aviso en español favor de enviar copia de este aviso y escriba a COLUMBIANA COUNTY DHS, P.O. BOX 9, , LISBON, OH 44432-0000.

END

SEQ# 00003 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000001
ODS 7900 (Rev. 9/97) NOTICE TYPE: BV61A1

Client Notice: BV62-A1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	93286-01
Date Implemented:	09/22/1995
Last Date Revised:	September, 1997

Description of Notice:	This is a refund notice that indicates a refund has occurred and the amount refunded.
Assistance Categories:	FS
Hearing Rights:	No
Program ID:	GBV233
Transaction ID:	N/A
Frequency:	Daily
Volume (est. monthly):	
Form Number:	ODHS 7902
Notes:	

0000001

CUYAHOGA COUNTY DHS
ENTITLEMENT SERVICES DIVISION
P.O. BOX 6048
CLEVELAND OH 44114-2919

IMPORTANT NOTICE

TO: JOHN DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 10/30/1998

Social Security number: 999-99-9999

We previously sent you a notice that we had received an offset payment from the Treasury Offset Program (TOP). We applied that money to a Food Stamp debt you owed us.

We have since then determined that we were incorrect to have collected $26.10 of your tax refund. We are returning the money to you. After this change, the balance and the status of this debt are as follows:

Claim Number	Overpayment Period	Balance	Status
9999999999/FS /01/01	05/89 - 09/89	$.00	CLOSED
	TOTAL	$.00	

You may still be responsible to pay this debt. You may also have other debts which were not referred to the TOP. If so, we intend to collect them. To arrange to pay this debt or talk about it, please contact the county department of human services in which you last applied for benefits.

Este aviso es para informarle que vamos a embargar su reembolso de impuestos federales sobre ingreso. Esta acción es para recuperar un pago en exceso de estampillas de comida. Si quiera recibir una copia de este aviso en español favor de enviar copia de este aviso y escriba a CUYAHOGA COUNTY DHS, ENTITLEMENT SERVICES DIVISION, P.O. BOX 6048, CLEVELAND, OH 44114-2919.

END

Client Notice: BV63-A1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	93286-01
Date Implemented:	09/22/1995
Last Date Revised:	September, 1997

Description of Notice:	This is a reversal notice that indicates the reestablishment of a claim due to a reversal.
Assistance Categories:	FS
Hearing Rights:	No
Program ID:	GBV233
Transaction ID:	N/A
Frequency:	Daily
Volume (est. monthly):	
Form Number:	ODHS 7903
Notes:	

0000001

ATHENS COUNTY DHS
184 N. LANCASTER ST.

ATHENS OH 45701-0000

IMPORTANT NOTICE

TO: JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 10/30/1998

Social Security Number: 999-99-9999

We previously sent you a notice that we had received an offset payment from the Treasury Offset Program (TOP). We applied that money to a Food Stamp debt you owed us.

We have since been told by the TOP that $443.00 of that payment was incorrect. We have returned that money to the TOP. After this change, the balance and the status of this debt are as follows:

Claim Number	Overpayment Period	Balance	Status
9999999999/FS /01/03	06/93 - 07/93	$339.00	OPEN
9999999999/FS /01/04	12/94 - 02/95	$104.00	OPEN
	TOTAL	$443.00	

You are still responsible to pay this debt. You may also owe us other debts which were not referred to the TOP. If so, we intend to collect them. To arrange to pay this debt or talk about it, please contact the county department of human services in which you last applied for benefits.

Este aviso es para informarle que vamos a embargar su reembolso de impuestos federales sobre ingreso. Esta acción es para recuperar un pago en exceso de estampillas de comida. Si quiera recibir una copia de este aviso en español favor de enviar copia de este aviso y escriba a ATHENS COUNTY DHS, 184 N. LANCASTER ST., , ATHENS, OH 45701-0000.

END

SEQ# 00001 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000001
ODS 7900 (Rev. 9/97) NOTICE TYPE: BV63A1

Client Notice: BV64-A1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	93286-01
Date Implemented:	09/22/1995
Last Date Revised:	September, 1997

Description of Notice:	This is a cancellation notice which explains referral has been canceled and reason. (Bankruptcy/Not Legally Enforceable)
Assistance Categories:	FS
Hearing Rights:	No
Program ID:	GBV233
Transaction ID:	N/A
Frequency:	Daily
Volume (est. monthly):	
Form Number:	ODHS 7904
Notes:	

0000001

DELAWARE COUNTY DHS
149 N. SANDUSKY STREET

DELAWARE OH 43015-0000

IMPORTANT NOTICE

TO: JOHN DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 08/24/1998

Social Security Number: 999-99-9999

We previously sent you a notice that we intended to refer a food stamp debt you owed us to the Treasury Offset Program (TOP) for collection from your eligible Federal payments.

We have since determined that all or some of the claims we intended to refer are not past due or are not legally enforceable. Therefore, all or part of the amount we stated on our initial notice will not be referred to the TOP.

You may still owe us money even if we are not referring you to the TOP. If so, we intend to collect it. To arrange to pay this debt or to talk about it, please contact the county department of human services where you last applied for benefits.

Este aviso es para informarle que vamos a embargar su reembolso de impuestos federales sobre ingreso. Esta acción es para recuperar un pago en exceso de estampillas de comida. Si quiera recibir una copia de este aviso en español favor de enviar copia de este aviso y escriba a DELAWARE COUNTY DHS, 149 N. SANDUSKY STREET, , DELAWARE, OH 43015-0000.

END

SEQ# 00004
ODS 7900 (Rev. 9/97)

THIS SPACE FOR OFFICIAL USE ONLY

PRINT SEQ. 0000001
NOTICE TYPE: BV64A1

Client Notice: BV70A1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number: 00172-08

Date Implemented: 10/01/00

Last Date Revised: 10/00

Description of Notice: 30 Day State Tax Offset Notice. This notice indicates the intent of the state to refer client for State Tax Offset.

Assistance Group(s): All

Hearing Rights: No

Program ID: GBV329

Transaction ID:

Frequency: Daily

Volume (est. monthly): 1,200

Form Number: ODHS 7900

Notes:

0000001

LUCAS COUNTY DJFS
COLLECTION UNIT
P.O. BOX 10007
TOLEDO OH 43699-1007

IMPORTANT NOTICE

TO: JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 08/24/2000

Social Security Number: 999-99-9999

You have not paid the amount you owe to the Department of Job and Family Services. If you do not pay your debt or take other actions described below before 30 days from the date of this letter, we will submit your debt to the Ohio Department of Taxation (ODT). Listed below is the debt we are trying to collect:

Claim Number	Overpayment Period	Balance
6666666666/ADC /01/01	03/00 - 02/00	$400.00
	TOTAL	$400.00

Once your debt is submitted, the ODT will withhold your 2000 Ohio income tax refund to satisfy all or part of your debt. This process, known as "offset", is authorized by Section 5101.184 of the Ohio Revised Code.

TO STOP THE TAX OFFSET: You must do one of the following by 30 days from the mailing date of this letter:

REPAY YOUR DEBT: To repay your debt or to talk about it or to ask questions about this letter, call or write to:

Phone: 1-888-245-8999
Local: 419-245-8999

LUCAS COUNTY DJFS
COLLECTION UNIT
P.O. BOX 10007
TOLEDO OH 43699-1007

If you come to the county department of job and family services to pay the debt, you should bring this letter with you.

KEEP READING >>>>

AGREE TO A REPAYMENT PLAN: Acceptable repayment arrangements are as follows:

* If the total of the above-listed debt is $500 or less, you must pay it in full within 30 days of the mailing date of this notice.

* If the total of the above-listed debt is more than $500, you must, within 30 days of the mailing date of this notice, pay $500 dollars and sign an agreement to repay the balance in regular payments.

REQUEST A REVIEW IF YOU BELIEVE THE DEBT IS NOT OWED: If you believe that all or part of the debt is not past due or is not legally enforceable, you can request a review by writing to the above address. You must send evidence to support your position and you must include your Social Security Number. If someone else makes a written request for a review for you, it must include a statement, signed by you, telling us that person is your representative.

If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio Legal Services Association, toll-free at 1-800-589-5888, for the local number.

END

Client Notice: BV71A1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number: 00172-08

Date Implemented: 10/01/00

Last Date Revised: 10/00

Description of Notice: State Offset Notice - Indicates a collection and the status of outstanding claims.

Assistance Group(s): All

Hearing Rights: No

Program ID: GBV329

Transaction ID:

Frequency: Daily

Volume (est. monthly): 1,200

Form Number: ODHS 7900

Notes:

0000001

ATHENS COUNTY DHS
184 N. LANCASTER ST.

ATHENS OH 45701-0000

IMPORTANT NOTICE

TO: JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 10/03/2000

Social Security Number: 999-99-9999

We have recently collected $974.00 on a debt you owed us because you had received overpaid food stamp benefits. This collection was made under the authority of the Treasury Offset Program. It may have been recovered in a single collection or in a series of collections. The above amount has been applied to your food stamp debt. The balance and the status of this debt are as follows:

Claim Number	Overpayment Period	Balance	Status
9999999999/FS /01/01	12/91 - 02/93	$1,694.00	OPEN
	TOTAL	$1,694.00	

The federal agency which made the collection may also have advised you of the amount it collected. The amount collected may be greater than the amount stated in this notice. If so, the difference is due to an administrative fee for that collection.

The amount of the administrative fee you paid does not reduce the amount you owe for overpaid food stamp benefits.

You still owe us any remaining balance on this debt. You may also have other debts to the department which were not referred to the Treasury Offset Program. We still intend to collect these debts. To arrange to pay these debts or to talk about them, please contact the county department of job and family services.

Este aviso es para informarle que vamos a embargar su reembolso de impuestos federales sobre ingreso. Esta acción es para recuperar un pago en exceso de estampillas de comida. Si quiera recibir una copia de este aviso en español favor de enviar copia de este aviso y escriba a ATHENS COUNTY DHS, 184 N. LANCASTER ST., , ATHENS, OH 45701-0000.

END

Client Notice: BV72A1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number: 00172-08

Date Implemented: 10/01/00

Last Date Revised: 10/00

Description of Notice: This is a refund notice that indicates a refund has occurred and the amount refunded.

Assistance Group(s): All

Hearing Rights: No

Program ID: GBV329

Transaction ID:

Frequency: Daily

Volume (est. monthly): 10

Form Number: ODHS 7900

Notes:

0000001

IMPORTANT NOTICE

CHAMPAIGN COUNTY DJFS
2380 S. U.S. HIGHWAY #68
P.O. BOX 353
URBANA OH 43078-0000

TO: JOHN DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 08/24/2000

Social Security Number: 999-99-9999

On 5/19/1999, we sent you a notice that we had received some or all of your 2000 Ohio income tax refund from the Ohio Department of Taxation (ODT). We applied that money to a debt you owed us.

We have since then determined that we were incorrect to have collected all or part of the amount we took from your Ohio income tax refund. We are returning the money to you. After this change, the balance and the status of this debt are as follows:

Claim Number	Overpayment Period	Balance	Status
9999999999/FS /01/01	09/95 - 12/95	$901.00	OPEN
	TOTAL	$901.00	

You may still be responsible to repay this debt. You may also owe us other debts which were not referred to the ODT. If so, we intend to collect them. To arrange to pay this debt or to talk about it, contact the county department of job and family services from which you received overpaid benefits.

END

SEQ# 00001
ODS 7900 (Rev. 8/00)

THIS SPACE FOR OFFICIAL USE ONLY

PRINT SEQ. 0000001
NOTICE TYPE:BV72A1

Client Notice: BV74A1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number: 00172-08

Date Implemented: 10/01/00

Last Date Revised: 10/00

Description of Notice: This is a camcellation notice which explains referral has been canceled and reason (Bankruptcy/Not Legally Enforceable).

Assistance Group(s): All

Hearing Rights: No

Program ID: GBV329

Transaction ID:

Frequency: Daily

Volume (est. monthly): 500

Form Number: ODHS 7900

Notes:

0000001

ATHENS COUNTY DJFS
184 N. LANCASTER ST.

ATHENS OH 45701-0000

IMPORTANT NOTICE

TO: JOHN DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 08/10/2000

Social Security Number: 999-99-9999

On 5/19/1999, we sent you a notice that we intended to refer an Aid to Dependant Children (ADC) or Ohio Works First (OWF) debt you owed us to the Ohio Department of Taxation (ODT) for collection from your 2000 Ohio income tax refund.

We have since determined that all or part of that debt is not past due or is not legally enforceable. Therefore, we will not refer it to the ODT at this time.

You may still owe us money, even though we are not referring this debt to the ODT. If so, we intend to collect it. To arrange to pay this debt or to talk about it, contact the county department of job and family services where you received overpaid benefits.

END

Client Notice: CM01-E1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	December, 1997

Description of Notice:	Expiration of Food Stamps - non MR (monthly repeating)
Assistance Categories:	FS
Hearing Rights:	No
Program ID:	GCL009
Transaction ID:	
Frequency:	Daily
Volume (est. monthly):	
Form Number:	DHS 8516
Notes:	

0000078 WDLC 0075

HAMILTON COUNTY DEPT OF HUMAN SERVICES
222 E. CENTRAL PARKWAY

CINCINNATI OH 452020000

IMPORTANT NOTICE

JANE DOE
111 MAIN ST.

ANYWHERE, USA 11111-1111

Mailing Date: 05/11/1998
From: MS. D COLTER
Phone: (513) 946-1185 Ext:

Worker ID: WDLC31
Case Number: 1111111111
AG Name: JANE DOE

Your food stamp certification will end on 06/30/1998. You must now reapply for food stamps.

You will receive a separate notice on approximately the 17th of this month informing you of your interview time, date and location. If you miss your scheduled interview, ask the county department of human services to reschedule the interview. If you do not receive an appointment notice, please contact your caseworker to schedule an interview.

You or your authorized representative must complete the reapplication process by 6/15/1998. The assistance group must complete the reapplication interview timely and provide all required verification within 10 days of the request in order to receive uninterrupted benefits. If we find during the interview and review of the completed application that your assistance group is still eligible, you will continue to receive food stamps without interruption. If you have not contacted your caseworker by 6/ 15/1998, your benefits may be late. Failure to complete a scheduled reapplication interview will result in benefits being discontinued.

If you fail to complete a timely reapplication for food stamps and any members of your assistance group are currently mandatory Employment and Training Program participants, the $25 per participant, per month work allowance check will be stopped at the end of your current certification period.

NOTE: If all members of your assistance group are now receiving Supplemental Security Income (SSI) or plan to apply for SSI, you may reapply for food stamps at the social security office instead of filing your application at the food stamp office. If you choose to do this, the social security office must also receive your application by the dates shown above. They will send it to the food stamp office for processing.

The assistance group has a right to request and file an application by mail or through an authorized representative. The application must be accepted if it is signed and contains a legible name and address.

If you do not agree with the action on your case, you may request a fair hearing.
If you do not understand or have any questions about this notice, please contact the worker named above.

END

SEQ# 0026247 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000078
ODS 8516 (Rev. 12/97) 1111111111/FS /01 NOTICE TYPE: CM01E1

Client Notice: CM03-N1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	December, 1997

Description of Notice:	New caseworker notice; Generate one per case.
Assistance Categories:	All
Hearing Rights:	No
Program ID:	GCL004
Transaction ID:	CLCA
Frequency:	Daily
Volume (est. monthly):	
Form Number:	DHS 8518
Notes:	Open AGs only.

0000045 WDJM 0021

FAIRFIELD COUNTY DEPT OF HUMAN SERVICES
P.O. BOX 890

LANCASTER OH 431300000

IMPORTANT NOTICE

JANE DOE
111 MAIN ST.

ANYWHERE, USA 11111-1111

Mailing Date: 05/13/1998
From: DEBRA J KENNEDY
Phone: (614) 653-1701 Ext:

Worker ID: WDJM23
Case Number: 1111111111
AG Name: JANE DOE

Dear JANEDOE

Your case has been assigned to a new caseworker. Your new worker is:

DEBRA J KENNEDY
P.O. BOX 890

LANCASTER OH 431300000

If you do not understand or have questions about this notice, please contact the worker named above.

END

SEQ# 0022369 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000045
ODS 8518 (Rev. 12/97) 1111111111/MA A/02 NOTICE TYPE: CM03N1

Client Notice: CM04-P1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	95304-09
Date Implemented:	N/A
Last Date Revised:	December, 1997

Description of Notice:	Application followup letter; Generate one per pending AG
Assistance Categories:	All AGs.
Hearing Rights:	No
Program ID:	GCL009
Transaction ID:	
Frequency:	Daily
Volume (est. monthly):	22000
Form Number:	DHS 8519
Notes:	Generated when AG is still pending 20 days from signature date (10 days for the follow: MAZ and MAZP).◙Added self-sufficiency contract to the outstanding verifications checklist (8/1/96)

0000043 WMLH 0066

FAIRFIELD COUNTY DEPT OF HUMAN SERVICES
P.O. BOX 890

LANCASTER OH 431300000

IMPORTANT NOTICE

As of 05/08/1998 you have used 03 months of your initial 36 months of Ohio Works First benefit eligibilty. If you continue to be eligible, you have 33 months remaining. After you have used up you 36 months, you might be eligible for additional months. See your caseworker.

JANE DOE
111 MAIN ST.

ANYWHERE, USA 11111-1111

Mailing Date: 05/11/1998
From: MISTY L HUSTON
Phone: (614) 653-1701 Ext: 6808

Worker ID: WMLH23
Case Number: 1111111111
AG Name: JANE DOE

Dear JANE DOE

Your application for public assistance has been pending since 04/21/1998. In order to determine your eligibility, verification of your statements on the application was requested during your application interview. The following verifications were requested but have not been received:

JANE DOE

PIP ADDRESS VERIFICATION
RESIDENT OF STATE

IT WILL BE NECESSARY FOR YOU TO PROVIDE THIS INFORMATION BY 05/21/1998. FAILURE TO SUBMIT THE REQUIRED INFORMATION MAY RESULT IN A DENIAL OF YOUR APPLICATION. IF YOU HAVE TROUBLE OR CANNOT OBTAIN ANY OR ALL OF THE INFORMATION NEEDED, PLEASE CONTACT YOUR CASEWORKER IMMEDIATELY IN ORDER THAT HE/SHE MAY HELP YOU IN OBTAINING THE VERIFICATIONS REQUIRED.

If you are pregnant and are in immediate need of a health card, and your income is at or below The Healthy Start standard for your family size, the CDHS can determine your eligibility for Expedited Medicaid with proof of identity and pregnancy. All Medicaid covered services, with the exception of inpatient hospital care, will be covered under the expedited card.

If you have any questions or need help in obtaining the information requested, please contact your caseworker.

END

Client Notice: CM05-R1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	December, 1997

Description of Notice:	Notice of failure to submit resource documentation; When any spousal resource verification codes not equal to yes.
Assistance Categories:	MA-A, -AP, -B, -BP, D -DP
Hearing Rights:	No
Program ID:	GAE501
Transaction ID:	Authorization
Frequency:	Daily
Volume (est. monthly):	
Form Number:	DHS 8542
Notes:	Generated when there is an institutionalized individual and a community spouse.

Client Notice: CS01-C2

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	95304-09
Date Implemented:	N/A
Last Date Revised:	December, 1996

Description of Notice:	Notice of application appointment interview; Worker Type is the activity code of the interview.
Assistance Categories:	All AGs
Hearing Rights:	No
Program ID:	GCS300
Transaction ID:	
Frequency:	Daily
Volume (est. monthly):	400
Form Number:	DHS 8520
Notes:	

0000060 WBJK

FRANKLIN CO COC COUNTY DEPT OF HUMAN SERVICES
3723 SOUTH HIGH STREET

COLUMBUS OH 432070000

IMPORTANT NOTICE

JANE DOE
111 MAIN ST.

ANYWHERE, USA 11111-1111

Mailing Date: 05/13/1998
From: BRENDA J KNIGHT
Phone: (614) 492-6942 Ext:

Worker ID: WBJK25
Case Number: 1111111111
AG Name:

Dear

Our records show that on 00/00/0000 you contacted our department to make an application for assistance. In order to determine initial eligibility a **FACE-TO-FACE** interview is required.

An appointment has been scheduled for you with:

BRENDA J KNIGHT
FRANKLIN CO COC COUNTY DEPARTMENT OF HUMAN SERVICES
3723 SOUTH HIGH STREET

COLUMBUS OH 432070000

on 05/27/1998 at 7:00 A.M.

When you report for your appointment, **BRING THIS LETTER** and all of the following information that pertains to members of your assistance group. If you have already provided verification of social security number, identity, age, citizenship/alien status, you do not need to bring these with you.

For a list of documents generally required to verify eligibility factors, see page two.

If you have trouble or cannot obtain any or all of the information needed, please contact your caseworker in order that she/he may help you in obtaining the required information.

PLEASE BE ON TIME. FAILURE TO KEEP THIS APPOINTMENT MAY RESULT IN YOUR ASSISTANCE BEING DECREASED, DENIED, OR TERMINATED. IF YOU CANNOT KEEP THIS APPOINTMENT FOR ANY REASON, NOTIFY THE CASEWORKER NAMED ABOVE.

If your family is applying for cash assistance, each adult member 18 years of age or older should come to the scheduled interview, if possible.

KEEP READING >>>

SEQ# 0025580 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000060
ODS 8520 (Rev. 12/96) 1111111111//00 NOTICE TYPE: CS01C2

If you miss your first interview, you must contact the county department of human services (CDHS).

Ask to reschedule your interview.

If you miss your interview and do not contact the CDHS, your benefits may be affected. The CDHS may deny your application if it has not heard from you within 30 days from the date you file your application.

APPLICATION/REAPPLICATION VERIFICATION REQUEST

PROOF OF IDENTITY:

You must provide one of the items listed below for yourself and each member of your family.

* drivers license
* state identification card
* school identification card
* work badge or building pass
* draft card or military ID
* U.S. passport or U.S. ID card
* credit card with signature
* clinic card or shot record (for pre-schoolers only)
* current report card, if available

PROOF OF AGE:

You must provide one of the items listed below for yourself and each member of your family.

* birth certificate
* delayed birth certificate
* baptismal record
* school record
* state or federal census record
* insurance policy
* marriage certificate (not license)
* military discharge papers
* draft card
* U.S. passport
* drivers license

PROOF OF CITIZENSHIP OR ALIEN STATUS:

You must provide one of the items listed below for yourself and each member of your family.

* birth certificate
* baptismal record
* U.S. passport
* naturalization certificate
* consular report of birth
* Ins I-94, I-151, or I-551
* alien registration card
* other immigration and naturalization service documents

PROOF OF INSURANCE VALUE:

You must provide the following if you have insurance on yourself or any family member.

* insurance policies (life, medical)
* statement from agent showing present cash value of any life insurance policy
* Medicare card

PROOF OF PREGNANCY:

You must provide a statement from your doctor or clinic which includes the estimated date of delivery.

PROOF OF ABSENT PARENT:

You must provide one of the items listed below.

* death certificate
* divorce papers
* separation papers
* court support order
* proof of incarceration
* letter from red cross or military

PROOF OF ASSETS:

You must provide all of the following items that apply to your assistance group.

* a written statement of cash on hand
* savings account passbook
* checking account statement
* trust fund statement
* stocks or bonds
* motor vehicle(s) title
* nonhomestead property mortgage book

PROOF OF INCAPACITY/DISABILITY:

You must provide one of the items below if applicable to your assistance group.

* signed statement from your doctor explaining your medical condition
* referral letter from the social security administration (SSA, SSI)
* referral letter from the Bureau of Vocational Rehabilitation (BVR)

KEEP READING >>>

PROOF OF RESIDENCY:

You must provide one of the items listed below

* rent receipt with your name, address, amount paid, and landlord's name and phone number
* mortgage book
* letter with your name, address, amount paid, from management, mortgage company, or person providing you with shelter.

UTILITIES, HOME INSURANCE, PROPERTY TAXES:

You must provide your last receipt if you pay any of the following.

* telephone
* gas or oil
* electric
* water
* sewer
* home insurance
* property tax statement

PROOF OF INCOME:

You must provide all of the following items that apply to your assistance group.

* last 4-6 weeks pay check stubs
* letter from employer
* court support order
* benefits check or photo copy
* benefits letter
* if self-employed, copy of last income tax statement
* rental income (statement from tenant)
* strike pay
* if self-employed, books or bookkeeper's name and phone number

PROOF OF EMPLOYMENT TERMINATION:

You must provide one of the items below

* notification letter from employer which shows the reason employment ended, the date employment began, the date employment ended, and the amount of the last pay
* name, address, and telephone number of former employer(s)

TANF ONLY:

You must provide all of the items listed below:

* proof of marriage or paternity
* employment registration card
* proof of any wages both parents earned during the last 24 months

PROOF OF INELIGIBILITY FOR BENEFITS:

You must provide a letter or form which shows ineligibility or expiration of any of the following benefit programs for which you have applied.

* social security
* supplemental security income
* veterans benefits
* unemployment compensation
* worker's compensation
* disability or sick benefits
* union fund or pension benefits
* railroad retirement benefits

NOTE: To receive a deduction for the following expenses you must report and provide verification to your caseworker of: rent or mortgage payment, utility and/or other shelter costs, medical expenses, dependent care expenses, and legally-obligated child support paid to a non-household member. Failure to report or verify any of the above-listed expenses will be seen as a statement by your household that you do not wanrt to receive a deduction for the unreported expense.

END

Client Notice: CS02-C3

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	95304-09
Date Implemented:	N/A
Last Date Revised:	December, 1997

Description of Notice:	Notice of reapplication interview; Worker Type is the activity code of the interview.
Assistance Categories:	All AGs
Hearing Rights:	No
Program ID:	GCS120, GCS300
Transaction ID:	
Frequency:	Monthly
Volume (est. monthly):	
Form Number:	DHS 8521
Notes:	

0000038 WMJP 1002

KNOX COUNTY DEPT OF HUMAN SERVICES
117 E. HIGH STREET 3ND FLR

MT. VERNON OH 430500000

IMPORTANT NOTICE

JANE DOE
111 MAIN ST.

ANYWHERE, USA 11111-1111

Mailing Date: 05/13/1998
From: MARY JANE PRIBONIC
Phone: (614) 397-7177 Ext: 2170

Worker ID: WMJP42
Case Number: 1111111111
AG Name: JANE DOE

Dear JANE DOE ,

Periodically your MEDICAID FOR THE AGED assistance case must be reviewed. The purpose is to see if you are still eligible for benefits and if you are receiving the correct amount. In order for this review to be completed, a **FACE-TO-FACE** interview is required.

An appointment has been scheduled for you with:

MARY JANE PRIBONIC
KNOX COUNTY DEPARTMENT OF HUMAN SERVICES
117 E. HIGH STREET 3ND FLR

MT. VERNON OH 430500000

on 05/27/1998 at 11:45 A.M.

When you report for your appointment, **BRING THIS LETTER** and all of the following information that pertains to members of your assistance group. If you have already provided verification of social security number, identity, age, citizenship/alien status, you do not need to bring these with you.

For a list of documents generally required to verify eligibility factors, see page two.

If you have trouble or cannot obtain any or all of the information needed, please contact your caseworker in order that she/he may help you in obtaining the required information.

KEEP READING >>>

PLEASE BE ON TIME. FAILURE TO KEEP THIS APPOINTMENT MAY RESULT IN YOUR ASSISTANCE BEING DECREASED, DENIED, OR TERMINATED. IF YOU CANNOT KEEP THIS APPOINTMENT FOR ANY REASON, NOTIFY THE CASEWORKER NAMED ABOVE.

If your family is applying for cash assistance, each adult member 18 years of age or older should come to the scheduled interview, if possible.

If you miss your first interview, you must contact the county department of human services (CDHS). Ask to reschedule your interview. If you miss your interview and do not contact the CDHS your benefits may be affected.

If you are eligible for Medicare Part A (Hospital Insurance) and/or Medicare Part B (Supplemental Medical Insurance) through the Social Security Administration it is important to let your caseworker know. You may be eligible for either the Qualified Medicare Beneficiary (QMB) or Specified Low-Income Medicare Beneficiary (SLMB) Medicaid programs. If you are eligible for the QMB program, Medicaid will pay your Medicare premiums, coinsurance and deductibles. If you are eligible for the SLMB program, Medicaid will pay your Medicare Part B premium. If you are not sure if you are eligible for Medicare, ask your caseworker to help you find out if you are eligible for Medicare and QMB or SLMB Medicaid help.

APPLICATION/REAPPLICATION VERIFICATION REQUEST

PROOF OF IDENTITY:

You must provide one of the items listed below for yourself and each member of your family.

* drivers license
* state identification card
* school identification card
* work badge or building pass
* draft card or military ID
* U.S. passport or U.S. ID card
* credit card with signature
* clinic card or shot record (for pre-schoolers only)
* current report card, if available

PROOF OF AGE:

You must provide one of the items listed below for yourself and each member of your family.

* birth certificate
* delayed birth certificate
* baptismal record
* school record
* state or federal census record
* insurance policy
* marriage certificate (not license)
* military discharge papers
* draft card
* U.S. passport
* drivers license

PROOF OF INSURANCE VALUE:

You must provide the following if you have insurance on yourself or any family member.

* insurance policies (life, medical)
* statement from agent showing present cash value of any life insurance policy
* Medicare card

PROOF OF PREGNANCY:

You must provide a statement from your doctor or clinic which includes the estimated date of delivery.

PROOF OF ABSENT PARENT:

You must provide one of the items listed below.

* death certificate
* divorce papers
* separation papers
* court support order
* proof of incarceration
* letter from red cross or military

PROOF OF ASSETS:

You must provide all of the following items that apply to your assistance group.

* a written statement of cash on hand
* savings account passbook
* checking account statement
* trust fund statement
* stocks or bonds
* motor vehicle(s) title
* nonhomestead property mortgage book

KEEP READING >>>

PROOF OF CITIZENSHIP OR ALIEN STATUS:

You must provide one of the items listed below for yourself and each member of your family.

* birth certificate
* baptismal record
* U.S. passport
* naturalization certificate
* consular report of birth
* Ins I-94, I-151, or I-551
* alien registration card
* other immigration and naturalization service documents

PROOF OF RESIDENCY:

You must provide one of the items listed below

* rent receipt with your name, address, amount paid, and landlord's name and phone number
* mortgage book
* letter with your name, address, amount paid, from management, mortgage company, or person providing you with shelter.

UTILITIES, HOME INSURANCE, PROPERY TAXES:

You must provide your last receipt if you pay any of the following.

* telephone
* gas or oil
* electric
* water
* sewer
* home insurance
* property tax statement

PROOF OF INCOME:

You must provide all of the following items that apply to your assistance group.

* last 4-6 weeks pay check stubs
* letter from employer
* court support order
* benefits check or photo copy
* benefits letter
* if self-employed, copy of last income tax statement
* rental income (statement from tenant)
* strike pay
* if self-employed, books or bookkeeper's name and phone number

PROOF OF INCAPACITY/DISABILITY:

You must provide one of the items below if applicable to your assistance group.

* signed statement from your doctor explaining your medical condition
* referral letter from the social security administration (SSA, SSI)
* referral letter from the Bureau of Vocational Rehabilitation (BVR)

PROOF OF EMPLOYMENT TERMINATION:

You must provide one of the items below

* notification letter from employer which shows the reason employment ended, the date employment began, the date employment ended, and the amount of the last pay
* name, address, and telephone number of former employer(s)

TANF ONLY:

You must provide all of the items listed below:

* proof of marriage or paternity
* employment registration card
* proof of any wages both parents earned during the last 24 months

PROOF OF INELIGIBILITY FOR BENEFITS:

You must provide a letter or form which shows ineligibility or expiration of any of the following benefit programs for which you have applied.

* social security
* supplemental security income
* veterans benefits
* unemployment compensation
* worker's compensation
* disability or sick benefits
* union fund or pension benefits
* railroad retirement benefits

NOTE - To receive a deduction for the following expenses you must report and provide verification to your caseworker of: rent or mortgage payment, utility and/or other shelter costs, medical expenses, dependent care expenses, and legally-obligated child support paid to a non-household member. Failure to report or verify any of the above-listed expenses will be seen as a statement by your household that you do not want to receive a deduction for the unreported expense.

END

Client Notice: CS03-C4

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	December, 1997

Description of Notice:	Notice of appointment letter (generic); Worker Type is the activity code of the interview.
Assistance Categories:	All AGs
Hearing Rights:	No
Program ID:	GCS300
Transaction ID:	
Frequency:	Daily
Volume (est. monthly):	700
Form Number:	DHS 8522
Notes:	

0000007 WJEC 2763

FRANKLIN CO COC COUNTY DEPT OF HUMAN SERVICES
80 E. FULTON ST.

COLUMBUS OH 432150000

IMPORTANT NOTICE

As of 05/12/1998 you have used 06 months of your initial 36 months of Ohio Works First benefit eligibility. If you continue to be eligible, you have 30 months remaining. After you have used up your 36 months, you might be eligible for additional months. See your caseworker.

JANE DOE
111 MAIN ST.

ANYWHERE, USA 11111-1111

Mailing Date: 05/13/1998
From: JACQUELINE E WHITNER
Phone: (614) 462-4126 Ext:

Worker ID: WJEC25
Case Number: 1111111111
AG Name: JANE DOE

Dear JANE DOE

Our records show that you must come in for a OHIO WORKS FIRST (OWF) general office visit.

An appointment has been scheduled for you with:

JACQUELINE E WHITNER
FRANKLIN CO COC COUNTY DEPARTMENT OF HUMAN SERVICES
80 E. FULTON ST.

COLUMBUS OH 432150000

on 05/27/1998 at 10:00 A.M.

PLEASE BE ON TIME FOR YOUR APPOINTMENT. BRING THIS LETTER WITH YOU.

IF YOU CANNOT KEEP THIS APPOINTMENT FOR ANY REASON, IMMEDIATELY NOTIFY THE CASEWORKER NAMED ABOVE.

END

SEQ# 0025964 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000007
ODS 8522 (Rev. 12/97) 1111111111/ADCR/01 NOTICE TYPE: CS03C4

Client Notice: CS04-A1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	December, 1997

Description of Notice:	Appointment Letter (JOBS); For JOBS assessment interview (rights, responsibilities)
Assistance Categories:	All AGs
Hearing Rights:	No
Program ID:	GCS300
Transaction ID:	
Frequency:	Daily
Volume (est. monthly):	4000
Form Number:	DHS 8558
Notes:	

0000009 WMZM 1007

ROSS COUNTY DEPT OF HUMAN SERVICES
150 E. 2ND ST.

CHILLICOTHE OH 456010000

IMPORTANT NOTICE

As of 05/12/1998 you have used 07 months of your initial 36 months of Ohio Works First benefit eligibility. If you continue to be eligible, you have 29 months remaining. After you have used up your 36 months, you might be eligible for additional months. See your caseworker.

JANE DOE
111 MAIN ST.

ANYWHERE, USA 11111-1111

Mailing Date: 05/13/1998
From: MARKELL E METTLER
Phone: (614) 773-2651 Ext: 3160

Worker ID: WMZM71
Case Number: 1111111111
AG Name: JANE DOE

Dear JANE DOE

Our records show that you must come in for a Job Opportunities and Basic Skills training (JOBS) assessment interview.

Your appointment has been scheduled with:

MARKELL E METTLER
ROSS COUNTY DEPARTMENT OF HUMAN SERVICES
150 E. 2ND ST.

CHILLICOTHE OH 456010000

on 05/27/1998 at 2:30 P.M.

PLEASE BE ON TIME FOR YOUR APPOINTMENT. BRING THIS LETTER WITH YOU.

IF YOU CANNOT KEEP YOUR APPOINTMENT FOR ANY REASON, IMMEDIATELY NOTIFY THE WORKER NAMED ABOVE.

RIGHTS

YOU HAVE THE RIGHT TO:

1. Receive copies of all written assessments and employability plans.
2. Receive notice of your right to request a state hearing related to JOBS program participation, and failure or refusal to participate.
3. Not be discriminated against when JOBS program assignments are made.
4. Receive the participant expense allowance for the authorized JOBS program activity.
5. Request a conciliation meeting to resolve disagreements concerning your participation in the JOBS program and to receive written instructions of how to request such a meeting.
6. Accept employment of at least thirty hours per week in place of the requirements of JOBS.

KEEP READING >>>

SEQ# 0025970 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000009
ODS 8558 (Rev. 12/97) 1111111111/ADCR/01 NOTICE TYPE: CS04A1

RESPONSIBILITIES

YOU ARE REQUIRED TO:

1. Go to your assessment, reassessment, and other required appointments.
2. Go to program, supportive service, or training sites at the required day and time.
3. Obey the rules at the JOBS program or training site, follow instuctions, and otherwise show good work habits and behavior.
4. Give the department of human services any information needed about a job you find.
5. Contact your JOBS worker, or other persons you are told to contact, within one hour of your starting time if you are sick or absent on those days you are to participate in a JOBS activity.
6. Participate in JOBS program activities for your scheduled number of hours.
7. Accept supportive services that are necessary in order for you to participate in a JOBS activity.
8. Contact the JOBS program staff if you disagree or have a concern about your JOBS program assignment.
9. Report to your worker any change in employment, education, training, or any situation that would affect your ability to participate in the JOBS program within ten calendar days of the change.
10. Provide your JOBS worker with verification of your attendance in a JOBS program activity if requested by your JOBS worker.
11. Contact your JOBS worker and provide a good cause reason within one hour of the scheduled start time when you do not participate as required in a JOBS program activity.
12. Contact the JOBS program staff by the 7th calendar day of each month if you have not received your schedule.
13. Report to a job site, to an employer for a scheduled job interview, or to any interviews or tests relating to employment when required by the JOBS program staff.
14. Accept a bona fide job offer.

The rights and responsibilities are contained in Ohio Administrative Code Rule 5101:1-47-16.

GOOD CAUSE

Some individuals are required to participate in the JOBS program as a condition of eligibility for cash assistance or food stamp benefits. The following are acceptable reasons, or good cause, for failing or refusing to participate in the JOBS program. You must contact the JOBS staff and provide a good cause reason within one hour of the scheduled start time when you do not participate as required in the program. This includes failing to report for an assessment or reassessment interview. You may be required to supply documentation of the good cause reason to your JOBS worker.

1. You were ill.
2. A member of your immediate family who is living with you was ill, and you were required to care for them.
3. You had a previously scheduled appointment for medical, dental, or vision care.
4. There was a death in your immediate family.
5. You had a previously scheduled job interview or civil service test.
6. You did not have supportive services that you needed in order to participate in the program.
7. You were excused for a reason that was approved by your JOBS worker.

The good cause reasons are contained in Ohio Administrative Code Rule 5101:1-47-37.

KEEP READING >>>

I have read or had these provisions explained to me. I understand and agree to cooperate with those requirements. I understand failure on my part to comply with JOBS program regulations could result in sanctions and loss of benefits and/or assistance. I have received the original of this notice.

Referral
Date: _____

Intake
Witness: _____

Applicant
Signature: _____ DATE: _____

Assessment
Witness: _____

Participant
Signature: _____ DATE: _____

END

Client Notice: DE01-B1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	December, 1997

Description of Notice:	Initial notice of child support disregard payment.
Assistance Categories:	ADC
Hearing Rights:	Yes
Program ID:	GDE120
Transaction ID:	
Frequency:	Daily
Volume (est. monthly):	1500
Form Number:	DHS 8561
Notes:	No previous child support disregard payments have been made and no previous notice has been sent.

0000046 WLAP 2002

LICKING COUNTY DEPT OF HUMAN SERVICES
P.O. BOX 5030

NEWARK OH 430585030

IMPORTANT NOTICE

JOHN DOE
111 MAIN ST.

ANYWHERE, USA 11111-1111

Mailing Date: 05/11/1998
From: LISA A PARKINSON
Phone: (614) 349-6277 Ext:

Worker ID: WLAP45
Case Number: 1111111111
AG Name: JOHN DOE

Dear JOHN DOE

A. General Information

As long as you are receiving TANF, your are entitiled to be paid up to the first $50 of the current child support collected for a month on behalf of children in your household. The amount you are paid will not be more than $50 per month. If the actual amount of current support collected is less than $50, you will be paid only the amount collected. These payments are called "child support disregard payments." They do no affect the amount of your TANF benefits but they may affect your food stamps.

B. Amount of Child Support Disregard Payment

Your local child support enforcement agency (CSEA) has reported to us that current child support was collected on your behalf for the month of 05/1997. Based on that report we have determined that you are eligible for a child support disregard payment of $50.00 for that month.

This check (and all future checks) will be mailed to you by the Ohio Department of Human Services from Columbus. If you don't receive your check within 14 days from the mailing date of this notice, call your CDHS caseworker.

C. Regulation

The regulation that supports our decision is OHIO PUBLIC ASSISTANCE MANUAL Section 1036.

KEEP READING >>>

SEQ# 0081175 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000046
ODS 8561 (Rev. 12/97) 1111111111/ADCR/02 NOTICE TYPE: DE01B1

D. Future Payments and Notices

As long as the current child support collected each month in the future by the CSEA entitles you to a disregard payment in the same amount as that stated above, you will continue to receive a check each month in that amount. Checks will come at about the same time each month and you will not receive another notice like this one. However, if the amount of your disregard payment is to change (increase, decrease, or stop), we will send you another notice to tell you about the change. If and when your TANF is terminated, current child support collections will be released to you, and you will not receive any more disregard payments or notices when that happens.

E. Hearings

If you do not agree with the amount of the disregard payment, you have the right to a state hearing. For a full explanation of your hearing rights, read page three of this notice. If you win your hearing, you may get an adjusted disregard payment.

Child Support Enforcement Agency (CSEA)

If you want to contact your local CSEA but don't know how, you can call the Ohio Department of Human Services toll free for help. Call 1-800-686-1556 and ask for the Office of Child Support Enforcement.

Records You May Review

You have the right to look at the record of your child support collections at the CSEA. Contact your local CSEA office.

You also have the right to look at the record of your child support disregard payments at your County Department of Human Services. Contact your CDHS caseworker.

AG Name:	Case Number:	Mailing Date:
JOHN DOE	1111111111	05/11/1998

YOUR RIGHT TO A STATE HEARING

This notice is to tell you about action we are taking on your case. If you do not understand this action, you should contact your caseworker. After talking to your caseworker, it is possible that we will change our decision or that you will agree with the action.

IF YOU DO NOT AGREE WITH THIS ACTION, YOU HAVE A RIGHT TO A STATE HEARING. A state hearing lets you or your representative (lawyer, welfare rights worker, friend or relative) give your reasons against the action. We will also attend the hearing to present our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

If you want a hearing, we must receive your hearing request within 90 days of the mailing date on this notice.

If someone else makes a written hearing request for you, it must include a written statement, signed by you, telling us that person is your representative. Only you can make a request by telephone.

If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association toll free, at 1-(800)-589-5888, for the local number.

If you want a state hearing, check the appropriate box, sign and date this form, and send ALL PAGES to the Ohio Department of Human Services, State Hearings, 30 East Broad Street, 31st Floor, Columbus, Ohio 43266-0423.

☐ I want a county conference and a state hearing.

☐ I want a state hearing only.

I want a state hearing.

SIGNATURE	DATE	TELEPHONE NUMBER

END

Client Notice: DE02-B2

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	December, 1997

Description of Notice:	Notice of change in child support disregard payment.
Assistance Categories:	ADC
Hearing Rights:	Yes
Program ID:	GDE120
Transaction ID:	
Frequency:	Daily
Volume (est. monthly):	400
Form Number:	DHS 8561
Notes:	Send when current monthly payment is greater than zero and not equal to the previous monthly payment.

IMPORTANT NOTICE

RICHLAND COUNTY DEPT OF HUMAN SERVICES
171 WESTINGHOUSE BUILDING
P.O. BOX 188
MAYBERRY OH 449010000

As of 06/01/1998 you have used 04 months of your initial 36 months of Ohio Works First benefit eligibility. If you continue to be eligible, you have 32 months remaining. After you have used up your 36 months, you might be eligible for additional months. See your caseworker.

JOHN DOE
111 MAIN ST.

ANYWHERE, USA 11111-1111

Mailing Date: 06/02/1998
From: JANE DOE
Phone: (301) 777-9311 Ext: 1111

Worker ID: WFAX00
Case Number: 7777777777
AG Name: JOHN DOE

Dear JOHN DOE

A. General Information

This notice is to tell you that the amount of your next child support disregard check will be different than the amount, if any, you received last month. That is because the amount of current child support collections reported to us by your local child support enforcement agency (CSEA) has changed.

As long as you are receiving TANF, your are entitiled to be paid up to the first $50 of the current child support collected for a month on behalf of children in your household. The amount you are paid will not be more than $50 per month. If the actual amount of current support collected is less than $50, you will be paid only the amount collected.

B. Amount of Child Support Disregard Payment

Based on the CSEA's report of current child support collected on your behalf for the month of 06/1998, you are eligible for a child support disregard payment of $50.00 for that month. If you do not receive your check within 14 days from the mailing date of this notice, call your CDHS caseworker.

As long as the current child support collected each month in the future by the CSEA entitles you to a disregard payment in the same amount as that stated above, you will continue to receive a check each month in that amount. The check will come at about the same time each month and you will not receive another notice like this one. However, if the amount of your disregard payment is to change (increase, decrease, or stop), we will send you another notice to tell you about the change. If and when your TANF is terminated, current child support collections will be released to you, and you will not receive any more disregard payments or notices when that happens.

C. Regulation

The regulation that supports our decision is OHIO PUBLIC ASSISTANCE MANUAL Section 1036.

KEEP READING >>>

D. Hearings

If you do not agree with the amount of the disregard payment, you have the right to a state hearing. For a full explanation of your hearing rights, read page three of this notice. If you win your hearing, you may get an adjusted disregard payment.

Child Support Enforcement Agency (CSEA)

If you want to contact your local CSEA but don't know how, you can call the Ohio Department of Human Services toll free for help. Call 1-800-686-1581 and ask for the Office of Child Support Enforcement.

Records You May Review

You have the right to look at the record of your child support collections at the CSEA. Contact your local CSEA office.

You also have the right to look at the record of your child support disregard payments at your County Department of Human Services. Contact your CDHS caseworker.

AG Name:	Case Number:	Mailing Date:
JOHN DOE	7777777777	06/02/1998

YOUR RIGHT TO A STATE HEARING

This notice is to tell you about action we are taking on your case. If you do not understand this action, you should contact your CDHS caseworker. After talking to your caseworker, it is possible that we will change our decision or that you will agree with the action.

IF YOU DO NOT AGREE WITH THIS ACTION, YOU HAVE A RIGHT TO A STATE HEARING. A state hearing lets you or your representative (lawyer, welfare rights worker, friend or relative) give your reasons against the action. We will also attend the hearing to present our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

If you want a hearing, we must receive your hearing request within 90 days of the mailing date on this notice.

If someone else makes a written hearing request for you, it must include a written statement, signed by you, telling us that person is your representative. Only you can make a request by telephone.

If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association toll free, at 1-(800)-589-5888, for the local number.

If you want a state hearing, check the appropriate box, sign and date this form, and send ALL PAGES to the Ohio Department of Human Services, State Hearings, 30 East Broad Street, 31st Floor, Columbus, Ohio 43266-0423.

☐ I want a county conference and a state hearing.

☐ I want a state hearing only.

I want a state hearing.

SIGNATURE	DATE	TELEPHONE NUMBER

END

Client Notice: DE02-B3

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	December, 1997

Description of Notice:	(CRIS) notice of change in child support disregard payment.
Assistance Categories:	ADC
Hearing Rights:	Yes
Program ID:	GDE120, GDE130
Transaction ID:	
Frequency:	Daily
Volume (est. monthly):	1
Form Number:	DHS 8530
Notes:	Send when the current monthly payment is equal to zero and the previous monthly payment is greater than zero.

IMPORTANT NOTICE

LAWRENCE COUNTY DEPT OF HUMAN SERVICES
4500 SOUTH SEVENTH STREET
P.O. BOX 539
IRONTON OH 456380000

As of 06/01/1998 you have used 04 months of your initial 36 months of Ohio Works First benefit eligibility. If you continue to be eligible, you have 32 months remaining. After you have used up your 36 months, you might be eligible for additional months. See your caseworker.

JOHN DOE
111 MAIN ST.

ANYWHERE, USA 11111-1111

Mailing Date: 06/02/1998
From: JOHN DOE
Phone: (301) 777-9311 Ext: 1111

Worker ID: WFAX00
Case Number: 8888888888
AG Name: JOHN DOE

Dear JOHN DOE

A. General Information

This notice is to tell you that you will no longer receive a child support disregard check, regardless of the amount of current child support collections reported to us by your local child support enforcement agency (CSEA).

The reason for this change is to comply with Substitute House Bill No. 408.

B. Hearings

If you do not agree with the amount of the disregard payment, you have the right to a state hearing. For a full explanation of your hearing rights, read page three of this notice. If you win your hearing, you may get an adjusted disregard payment.

Child Support Enforcement Agency (CSEA)

If you want to contact your local CSEA but don't know how, you can call the Ohio Department of Human Services toll free for help. Call 1-800-686-1581 and ask for the Office of Child Support Enforcement.

Records You May Review

You have the right to look at the record of your child support collections at the CSEA. Contact your local CSEA office.

You also have the right to look at the record of your child support disregard payments at your County Department of Human Services. Contact your CDHS caseworker.

KEEP READING >>>

AG Name:	Case Number:	Mailing Date:
JOHN DOE	8888888888	06/02/1998

YOUR RIGHT TO A STATE HEARING

This notice is to tell you about action we are taking on your case. If you do not understand this action, you should contact your CDHS caseworker. After talking to your caseworker, it is possible that we will change our decision or that you will agree with the action.

IF YOU DO NOT AGREE WITH THIS ACTION, YOU HAVE A RIGHT TO A STATE HEARING. A state hearing lets you or your representative (lawyer, welfare rights worker, friend or relative) give your reasons against the action. We will also attend the hearing to present our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

If you want a hearing, we must receive your hearing request within 90 days of the mailing date on this notice.

If someone else makes a written hearing request for you, it must include a written statement, signed by you, telling us that person is your representative. Only you can make a request by telephone.

If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association toll free, at 1-(800)-589-5888, for the local number.

If you want a state hearing, check the appropriate box, sign and date this form, and send ALL PAGES to the Ohio Department of Human Services, State Hearings, 30 East Broad Street, 31st Floor, Columbus, Ohio 43266-0423.

☐ I want a county conference and a state hearing.

☐ I want a state hearing only.

I want a state hearing.

SIGNATURE	DATE	TELEPHONE NUMBER

END

Client Notice: DE03-B4

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	December, 1997

Description of Notice:	Notice of additional child support disregard payment.
Assistance Categories:	ADC
Hearing Rights:	Yes
Program ID:	GDE120
Transaction ID:	
Frequency:	Daily
Volume (est. monthly):	14000
Form Number:	DHS 8531
Notes:	Send when the current month payment is equal to zero and the previous monthly payment is greater than zero.

0000001 WRLL 2406

MARION COUNTY DEPT OF HUMAN SERVICES
363 W. FAIRGROUND ST.
P.O. BOX 1817
MARION OH 433020000

IMPORTANT NOTICE

JANE DOE
111 MAIN ST.

ANYWHERE, USA 11111-1111

Mailing Date: 05/08/1998
From: ROBYN L LITTELL
Phone: (614) 387-8560 Ext: 0223

Worker ID: WRLL51
Case Number: 1111111111
AG Name: JANE DOE

Dear JANE DOE

A. General Information

This notice is to tell you that you are eligible to receive a child support disregard payment for which you were entitled prior to October 1, 1997.

B. Adjustment in Child Support Disregard Payment

We have determined that you are entitled to an adjustment in the child support disregard payment for the month of 09/1996. You have already been issued a disregard payment of $.00 for that month. We are now authorizing an additional $41.05. This check will be mailed to you by the Ohio Department of Human Services from Columbus. If you do not receive your check within 14 days from the mailing date of this notice, call your CDHS caseworker.

The reason for this adjustment is: ADDITIONAL CHILD SUPPORT PAYMENT RECEIVED

C. Regulation

The regulation that supports our decision is OHIO PUBLIC ASSISTANCE MANUAL Section 1036.

KEEP READING >>>

D. Hearings

If you do not agree with the amount of the disregard payment, you have the right to a state hearing. For a full explanation of your hearing rights, read page three of this notice. If you win your hearing, you may get an adjusted disregard payment.

Child Support Enforcement Agency (CSEA)

If you want to contact your local CSEA but don't know how, you can call the Ohio Department of Human Services toll free for help. Call 1-800-686-1556 and ask for the Office of Child Support Enforcement.

Records You May Review

You have the right to look at the record of your child support collections at the CSEA. Contact your local CSEA office.

You also have the right to look at the record of your child support disregard payments at your County Department of Human Services. Contact your CDHS caseworker.

AG Name:	Case Number:	Mailing Date:
JANE DOE	1111111111	05/08/1998

YOUR RIGHT TO A STATE HEARING

This notice is to tell you about action we are taking on your case. If you do not understand this action, you should contact your caseworker. After talking to your caseworker, it is possible that we will change our decision or that you will agree with the action.

IF YOU DO NOT AGREE WITH THIS ACTION, YOU HAVE A RIGHT TO A STATE HEARING. A state hearing lets you or your representative (lawyer, welfare rights worker, friend or relative) give your reasons against the action. We will also attend the hearing to present our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

If you want a hearing, we must receive your hearing request within 90 days of the mailing date on this notice.

If someone else makes a written hearing request for you, it must include a written statement, signed by you, telling us that person is your representative. Only you can make a request by telephone.

If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association toll free, at 1-(800)-589-5888, for the local number.

If you want a state hearing, check the appropriate box, sign and date this form, and send ALL PAGES to the Ohio Department of Human Services, State Hearings, 30 East Broad Street, 31st Floor, Columbus, Ohio 43266-0423.

☐ I want a county conference and a state hearing.

☐ I want a state hearing only.

I want a state hearing.

SIGNATURE	DATE	TELEPHONE NUMBER

END

Client Notice: EZ01-C1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	December, 1997

Description of Notice:	PAYEASE notice of credit
Assistance Categories:	FS
Hearing Rights:	No
Program ID:	GSC002
Transaction ID:	SC002
Frequency:	Daily
Volume (est. monthly):	0
Form Number:	DHS 8562

Notes:

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IMPORTANT NOTICE

MONTGOMERY COUNTY DEPT OF HUMAN SERVICES
74 E. CAIBOU-DEERSHED BLDG
P.O. BOX 700
DAYTON OH 454220000

As of 08/01/1996 you have used 04 months of your initial 36 months of Ohio Works First benefit eligibility. If you continue to be eligible, you have 32 months remaining. After you have used up your 36 months, you might be eligible for additional months. See your caseworker.

JOHN DOE
111 MAIN ST.

ANYWHERE, USA 11111-1111

Mailing Date: 08/02/1996
From: JOHN DOE
Phone: (301) 777-9311 Ext: 1111

Worker ID:
Case Number: 1000000000
AG Name: JOHN DOE

Dear JOHN DOE

The following transaction occurred:

at:

on: 06/01/1998

in the amount of: $.00

The above amount has been credited to your PAYEASE Food Stamp card for the following reason:

If you do not understand or have any questions, please call **CUSTOMER SERVICE 1-800-944-3273.**

END

Client Notice: EZ02-C1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	December, 1997

Description of Notice:	PAYEASE notice of charge
Assistance Categories:	FS
Hearing Rights:	No
Program ID:	GSC002
Transaction ID:	SC002
Frequency:	Daily
Volume (est. monthly):	0
Form Number:	DHS 8563

Notes:

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IMPORTANT NOTICE

MONTGOMERY COUNTY DEPT OF HUMAN SERVICES
74 E. CAIBOU-DEERSHED BLDG
P.O. BOX 700
DAYTON OH 454220000

As of 06/01/1998 you have used 04 months of your initial 36 months of Ohio Works First benefit eligibility. If you continue to be eligible, you have 32 months remaining. After you have used up your 36 months, you might be eligible for additional months. See your caseworker.

JOHN DOE
MAIN ST.

ANYWHERE, USA 11111-1111

Mailing Date: 06/02/1998
From: JANE DOE
Phone: (301) 777-9311 Ext: 1111

Worker ID:
Case Number: 2000000000
AG Name: JOHN DOE

Dear JOHN DOE

The following transaction occurred:

at:

on: 06/01/1998

in the amount of: $.00

The above amount has been charged to your PAYEASE Food Stamp card for the following reason:

If you do not understand or have any questions, please call **CUSTOMER SERVICE 1-800-944-3273.**

END

SEQ# 0013500 THIS SPACE FOR OFFICIAL USE ONLY
ODS 8563 (Rev. 12/97) 2000000000/FS /01 NOTICE TYPE: EZ02C1

Client Notice: EZ03-D1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	December, 1997

Description of Notice:	PAYEASE notice of debit
Assistance Categories:	FS
Hearing Rights:	No
Program ID:	GSC002
Transaction ID:	SC002
Frequency:	Daily
Volume (est. monthly):	0
Form Number:	DHS 8564

Notes:

0000

IMPORTANT NOTICE

MONTGOMERY COUNTY DEPT OF HUMAN SERVICES
74 E. CAIBOU-DEERSHED BLDG
P.O. BOX 700
DAYTON OH 454220000

As of 06/01/1998 you have used 04 months of your initial 36 months of Ohio Works First benefit eligibility. If you continue to be eligible, you have 32 months remaining. After you have used up your 36 months, you might be eligible for additional months. See your caseworker.

JOHN DOE
111 MAIN ST.

ANYWHERE, USA 11111-1111

Mailing Date: 06/02/1998
From: JOHN DOE
Phone: (301) 777-9311 Ext: 1111

Worker ID:
Case Number: 3000000000
AG Name: JOHN DOE

Dear JOHN DOE

The following transaction occurred:

at:

on: 06/01/1998

in the amount of: $.00

The above amount was not charged to your Payease Food Stamp card for reason of NON-SUFFICIENT FUNDS therefore, we have charged your card $.00 leaving a balance due of $.00.

If you do not understand or have any questions, please call **CUSTOMER SERVICE 1-800-944-3273.**

END

Client Notice: EZ04-N1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	December, 1997

Description of Notice:	PAYEASE notice of non-use of Food Stamp card
Assistance Categories:	FS
Hearing Rights:	No
Program ID:	GSC002
Transaction ID:	SC002
Frequency:	Daily
Volume (est. monthly):	3400
Form Number:	DHS 8565

Notes:

0000019 0000

BUTLER COUNTY DEPT OF HUMAN SERVICES
860 N.W. WASHINGTON BLVD.

HAMILTON OH 450130000

IMPORTANT NOTICE

JANE DOE
111 MAIN ST.

ANYWHERE, USA 11111-1111

Mailing Date: 05/13/1998
From:
Phone: Ext:

Worker ID:
Case Number: 1111111111
AG Name: JANE DOE

Dear JANE DOE

Our records show that you have not used your Food Stamp Card within the last 60 days.

FOR YOUR PROTECTION, if you card is not used by 06/10/1998 your card will no longer be accepted at the grocery store.

REMEMBER: If your card is lost or stolen or if you need assistance call:

CUSTOMER SERVICE 1-800-944-3273

END

SEQ# 0026026 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000019
ODS 8565 (Rev. 12/97) 1111111111/FS /01 NOTICE TYPE: EZ04N1

Client Notice: EZ04-N2

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	April, 2000

Description of Notice:	PAYEASE notice of non-use of Food Stamp card
Assistance Categories:	FS
Hearing Rights:	No
Program ID:	GSC002
Transaction ID:	SC002
Frequency:	Daily
Volume (est. monthly):	200
Form Number:	DHS 8565

Notes:

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0000191

LORAIN COUNTY DEPT OF HUMAN SERVICES
LORAIN CDHS
42485 NORTHRIDGE ROAD
ELYRIA OH 440350000

IMPORTANT NOTICE

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 02/18/2000
From:
Phone: Ext:

Worker ID:
Case Number: 9999999999
AG Name: JANE DOE

Dear JANE DOE

Our records show that you have not used your Food Stamp Card within the last 90 days.

Since you have not used your card, it will no longer be accepted at the grocery store as of 02/16/2000.

Before you can use your card at the grocery store, you must visit the Ohio Direction Card Office or call **1-800-944-3273.**

END

SEQ# 0018005 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000191
ODS 8565 (Rev. 12/97) 9999999999/FS /01 NOTICE TYPE: EZ04N2

Client Notice: HI01I1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number: 98084-12

Date Implemented: 01/01/00

Last Date Revised: 01/01/00

Description of Notice: The notice provides eligible individuals with their Certificate of Group Health Plan Coverage.

Assistance Group(s): All Medicaid except MAUS and MA L.

Hearing Rights: YES

Program ID: GCN093

Transaction ID:

Frequency: Monthly

Volume (est. monthly): 45,000

Form Number: DHS 8500

Notes:

WWMF 2008

0000001

IMPORTANT NOTICE

HIGHLAND COUNTY DEPT OF HUMAN SERVICES
1575 N. HIGH ST. SUITE 100

HILLSBORO OH 451330000

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 12/14/1999
From: WANDA M FOSTER
Phone: (937) 393-4278 Ext: 0236

Worker ID: WWMF36
Case Number: 9999999999
AG Name: JANE DOE

Dear JANE DOE

Enclosed are your Certificates of Group Health Plan Coverage.

KEEP READING >>>

SEQ# 0019757 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000001
ODS (Rev. 09/99) 9999999999/MA A/02 NOTICE TYPE: HI01I1

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CERTIFICATE OF GROUP HEALTH PLAN COVERAGE

IMPORTANT This certificate provides evidence of your prior health coverage through the state's medical assistance programs. You may need to furnish this certificate if you become eligible under a group health plan that excludes coverage for certain medical conditions that you or your family may have before you enroll. This certificate may need to be provided if medical advice, diagnoses, care, or treatment was recommended or received for the conditions within the 6-month period prior to your enrollment in the new plan. If you become covered under another group health plan, check with the plan administrator to see if you need to provide this certificate. You may also need this certificate to buy for yourself or your family, an insurance policy that does not exclude coverage for medical conditions that were present before you enroll.

1. Date of this certificate: 12/13/1999

2. Name of group health plan: MEDICAID

3. Name of participant: JANE DOE

4. Medical (MMIS) billing number of participant: 999999999999 DOB: 07/27/1933

5. For questions about the information provided on this certificate contact:

   HIGHLAND County Department of Human Services
   1575 N. HIGH ST. SUITE 100

   HILLSBORO OH 451330000

   County Worker: WANDA M FOSTER
   Phone: (937) 393-4278 Ext: 0236

6. Does the individual in line 3 have at least 18 months creditable coverage (disregarding the coverage before a 63-day break) ? **NO**

7. Dates of certifiable coverage:
   11/29/1997 - 05/31/1999

8. Date coverage ended: 05/31/1999

NOTE: Separate certificates will be furnished for each participant.

See the other side of this page to learn about the hearing rights you have on the information provided on this certificate.

PRINT SEQ. 0000001

Your Right to a State Hearing

The county department of human services is providing information concerning the time period that you received state medical assistance. If you have questions about the information on the front side of this certificate, you should contact your caseworker. It is possible that after discussing the material on this form, the information may be changed.

If you do not agree with the information on this form, you have a right to a state hearing. A state hearing lets you or your representative (lawyer, welfare rights worker, friend, or relative) give your reasons for disagreeing with the information contained on this certificate. The county department of human services will also attend the hearing to present its reason for providing this information. A hearing officer from the Ohio Department of Human Services will decide whether you or the county department of human services is right.

If you want a hearing, we must receive your hearing request within 90 days of the mailing date of this notice. You do not need to return this form if you agree with the information found on the certificate.

If someone else makes a written hearing request for you, it must include a written statement signed by you telling us that person is your representative. Only you can make a request by telephone.

If you want information on free legal services, but do not know the telephone number of your local legal aid office, you can call the Ohio State Legal Association, toll free, at 1-800-589-5888, to get the telephone number for your area.

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

☐ I want a county conference and a state hearing on the information listed on the Certificate of Creditable Coverage on the front side of this page. I disagree with the information shown on the certificate.

☐ I want a state hearing only.

I want a hearing.

Signature	Date	Telephone Number

PRINT SEQ. 0000001

Client Notice: HM01NP

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number: 00256-05

Date Implemented: 01/08/01

Last Date Revised: 01/01

Description of Notice: Healthy Start, Healthy Families or Ohio Works
First approval notice.

Assistance Group(s):

Hearing Rights: No

Program ID: GAE501

Transaction ID:

Frequency: Daily

Volume (est. monthly): 15,000

Form Number: DHS 5893

Notes:

WCLK 0068

0023386

EN ESPANOL 1-800-324-8680

HAMILTON DEPARMENT OF JOB AND FAMILY SERVICES
HEALTH CARE ENTROLLMENT SERVICES CENTER
505 SOUTH HIGH STREET
COLUMBUS, OHIO 43215

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 01/17/2001
Case Number: 9999999999/MA C/01
AG Name: JANE DOE

OHIO DEPARTMENT OF JOB AND FAMILY SERVICES
HEALTHY START, HEALTHY FAMILIES

As you know your application for Healthy Start, Healthy Families health care coverage has recently been approved. **Now you must choose how you and your family will continue to receive health care.** You can choose either a managed care plan (MCP) or the regular Medicaid card. The MCP offers the same services you get with the Medicaid card, but with some important extras, such as:

24-Hour Toll-Free Medical Help Line
Annual Physical Exams for Adults and Children
Special Prenatal and Newborn Programs
Expanded Selection of Eyewear
Help with Transportation to Medical Appointments

You can find out about the MCP in your county by calling the Consumer Hotline at **1-800-324-8680** and talking with an Enrollment Specialist. You can call Monday through Friday, 8:00 a.m. to 8:00 p.m.

You have until 02/05/2001 to choose either the MCP or the Medicaid card. If you do not make a choice for you and your family, you will be enrolled in the MCP. This could result in your having to change doctors or hospitals.

YOU ARE REQUIRED TO MAKE A CHOICE HOW YOU WANT TO RECEIVE HEALTH CARE.

Call 1-800-324-8680

For the hearing impaired call TDD/TTY 1-800-292-3572

END

Client Notice: HM01NV

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number: 00256-05

Date Implemented: 01/08/01

Last Date Revised: 01/01

Description of Notice: Healthy Start, Healthy Families or Ohio Works
First approval notice.

Assistance Group(s):

Hearing Rights: No

Program ID: GAE501

Transaction ID:

Frequency: Daily

Volume (est. monthly): 15,000

Form Number: DHS 5893

Notes:

WNRH 1013

0012986

EN ESPANOL 1-800-324-8680

STARK DEPARMENT OF JOB AND FAMILY SERVICES
HEALTH CARE ENTROLLMENT SERVICES CENTER
505 SOUTH HIGH STREET
COLUMBUS, OHIO 43215

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 01/10/2001
Case Number: 9999999999/MA C/01
AG Name: JANE DOE

OHIO DEPARTMENT OF JOB AND FAMILY SERVICES
HEALTHY START, HEALTHY FAMILIES AND OHIO WORKS FIRST

Your application for Healthy Start, Healthy Families or Ohio Works First has recently been approved. Now you can choose to receive health care through a managed care plan or MCP. The MCP will provide the same services you get with the Medicaid card, but with some important extras, such as:

Annual Physical Exams for Adults and Children
Special Prenatal and Newborn Programs
Expanded Selection of Eyewear
Help with Transportation to Medical Appointments

You can find out about the MCP in your county by calling the Consumer Hotline at **1-800-324-8680** and talking with an Enrollment Specialist. You can call Monday through Friday, 8:00 a.m. to 8:00 p.m.

Call 1-800-324-8680

For the hearing impaired call TDD/TTY 1-800-292-3572

END

Client Notice: HM01N1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number: 98173-03

Date Implemented: 08/01/98

Last Date Revised: 01/29/01

Description of Notice: Explain to the recipient that they must join an HMO by calling the special 1-800 number

Assistance Group(s): MA C, MA H, MA P, MA S, MA T, MA V, MA W, MA X, MA Y

Hearing Rights: NO

Program ID: GAE501

Transaction ID:

Frequency: Daily

Volume (est. monthly): 5000

Form Number: ODS 8593

Notes:

WKSS 1088

0000001

EN ESPANOL 1-800-324-8680

FRANKLIN DEPARMENT OF JOB AND FAMILY SERVICES
HEALTH CARE ENTROLLMENT SERVICES CENTER
505 SOUTH HIGH STREET
COLUMBUS, OHIO 43215

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 04/05/1999
Case Number: 9999999999/MA P/01
AG Name: JANE DOE

OHIO DEPARTMENT OF JOB AND FAMILY SERVICES
HEALTHY START, HEALTHY FAMILIES AND OHIO WORKS FIRST

Your application for Healthy Start, Healthy Families or Ohio Works First has recently been approved. Now you must choose a health care provider, called a managed care plan or MCP. This plan will provide the health care services you and your family now receive plus some important extras, such as:

Annual Physical Exams for Adults and Children
Special Prenatal and Newborn Programs
Expanded Selection of Eyewear
Help with Transportation to Medical Appointments

You can find out about the MCPs in your county by calling the Consumer Hotline at **1-800-324-8680** and talking with an Enrollment Specialist. You can call Monday through Friday, 8:00 a.m. to 8:00 p.m.

You have until 04/23/1999 to choose the MCP and the doctors that are right for you and your family. If you do not choose an MCP, one will be chosen for you. This could result in your having to change doctors or hospitals.

ENROLLMENT IN A MANAGED CARE PLAN IS REQUIRED FOR YOU TO CONTINUE TO RECEIVE HEALTH CARD.

Call 1-800-324-8680

For the hearing impaired call TDD/TTY 1-800-292-3572

END

SEQ# 3900001 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000001
ODS 8593 (Rev. 11/00) 9999999999/MA P/01 NOTICE TYPE: HM01N1

Client Notice: HM02N1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number: 99004-03

Date Implemented: 04/02/99

Last Date Revised: 01/29/01

Description of Notice: The notice is a notification of Managed Care Plan open enrollment.

Assistance Group(s):

Hearing Rights: No

Program ID:

Transaction ID: GAE826

Frequency: Daily

Volume (est. monthly): 20,000

Form Number: DHS 8500

Notes:

WDBW 1283

IMPORTANT NOTICE

CUYAHOGA COUNTY DEPT OF HUMAN SERVICES
MAIN OFFICE
1641 PAYNE AVE
CLEVELAND OH 441140000

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 11/28/2000
From: DELORIS BANKS-WILLIAMS
Phone: (216) 987-7724 Ext:

Worker ID: WDBW18
Case Number: 9999999999
AG Name: JANE DOE

Dear JANE DOE

YOUR MANAGED CARE PLAN OPEN ENROLLMENT MONTH IS FEBRUARY.

(EN ESPANOL 1-800-324-8680)

Because you are eligible for Healthy Start, Healthy Families Medicaid and live in **CUYAHOGA** county your Annual Managed Care Plan Open Enrollment month is **FEBRUARY.**

What does this mean for me?
If you are receiving health care services through a managed care plan, or MCP, **FEBRUARY** is the month when you can change to a different MCP if you want to for any reason.

What if I want to change MCPs?
If you want to change MCPs, you can call the Consumer Hotline at 1-800-324-8680 and ask to speak to an Enrollment Specialist. You can call toll-free Monday-Friday, 8 A.M. to 8 P.M.. The Enrollment Specialist can tell you about the other managed care plans available to you and make the change for you. When you call in **FEBRUARY** you will be enrolled in the new plan for **APRIL 1.** Once you get your new MCP member identification card and new member information, you will get all of your health care from the new MCP. You must stay in the MCP until your next Open Enrollment month, or February.

If you want to stay in the MCP you are currently in you don't need to do anything.

Can I change MCPs if it is not Open Enrollment Month?

Yes, you can change in certain cases. If you are not satisfied with your MCP, you can change MCPs in your first 3 (three) months of enrollment. At other times you can request a change if you have a problem staying in your MCP. This is called a "Just Cause" disenrollment. Just Cause is explained in your MCP member handbook. To find out if you will be allowed to change MCPs, call the Consumer Hotline toll-free at 1-800-324-8680 and ask to speak with an Enrollment Specialist. For the hearing impaired call TDD/TTY 1-800-292-3572.

END

Client Notice: HM02N2

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number: 99004-03

Date Implemented: 04/02/99

Last Date Revised: 01/29/01

Description of Notice: The notice is a notification of Managed Care Plan open enrollment.

Assistance Group(s):

Hearing Rights: No

Program ID:

Transaction ID: GAE826

Frequency: Daily

Volume (est. monthly): 6,000

Form Number: DHS 8500

Notes:

WLSH 1303

0000001

IMPORTANT NOTICE

SUMMIT COUNTY DEPT OF HUMAN SERVICES
37 N. HIGH ST.

AKRON OH 443080000

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 02/17/1999
From: RICK FRANKENSTEIN
Phone: (330) 643-7273 Ext:

Worker ID: WLSH77
Case Number: 9999999999
AG Name: JANE DOE

Dear JANE DOE

YOUR MANAGED CARE PLAN OPEN ENROLLMENT MONTH IS APRIL.

(EN ESPANOL 1-800-324-8680)

Because you are eligible for Healthy Start, Healthy Families Medicaid and live in **SUMMIT** county your Annual Managed Care Plan Open Enrollment month is **APRIL.**

What does this mean for me?
If you are receiving health care services through a managed care plan, or MCP, **APRIL** is the month when you can change to a different MCP or return to regular Medicaid if you want to for any reason.

If you want to stay in the MCP you are currently in you don't need to do anything.

What if I want to change MCPs or return to regular Medicaid?
If you want to change MCPs, or return to regular Medicaid, you can call the Consumer Hotline at 1-800-324-8680 and ask to speak to an Enrollment Specialist. You can call toll-free Monday-Friday, 8 A.M. to 8 P.M.. The Enrollment Specialist can tell you about the options available to you and make the change for you. When you call in **APRIL** the change you requested will be effective on **JUNE 1.** Once you get your new MCP member identification card and new member information, you will get all of your health care from the new MCP. If you asked to return to regular Medicaid, you will receive a monthly card and can use the card to get health care. You must stay in the MCP until your next Open Enrollment month, or April.

Can I request a change if it is not Open Enrollment Month?
Yes, you can change in certain cases. If you are not satisfied with your MCP, you can request a change in your first 3 (three) months of enrollment. At other times you can request a change if you have a problem staying in your MCP. This is called a "Just Cause" disenrollment. Just Cause is explained in your MCP member handbook. To find out if you will be allowed to change, call the Consumer Hotline toll-free at 1-800-324-8680 and ask to speak with an Enrollment Specialist. For the hearing impaired call TDD/TTY 1-800-292-3572.

END

Client Notice: HS01N1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number: 98198-05

Date Implemented: 11/16/99

Last Date Revised: 11/16/99

Description of Notice: This is a state hearing scheduling notice addressed to the appellant.

Assistance Group(s): All

Hearing Rights: NO

Program ID: GCN252

Transaction ID:

Frequency: Daily

Volume (est. monthly): 1,500

Form Number: ODS 4002

Notes:

STATE HEARING SCHEDULING NOTICE

0000001
COLUMBUS DISTRICT OFFICE HEARINGS UNIT
899 E. BROAD ST., 4TH FLR.

COLUMBUS OH 43205-1190

JANE DOE
111 MAIN ST

ANYWHERE OH 99999

Assistance Group Name: JANE DOE
Mailing Date: 12/10/1999 Assistance Group Number: 9999999999 County: FRANKLIN
Request Date: 12/01/1999 Program: MED Appeal Number: 9999999

We received your request for a state hearing. **Your hearing has been scheduled for:**

PLACE OF HEARING	**DATE OF HEARING**
FRANKLIN CDHS 80 E. FULTON ST. COLUMBUS OH 43215-5127	SUNDAY DECEMBER 00, 1999 **TIME OF HEARING** 09:00 AM

If you no longer want a hearing, or can't come to the hearing as scheduled, let us know right away. If you do not show up for your hearing, your case will be dismissed. Call the district hearing section at 1-800-686-1568 if you have questions about this hearing.

Below is an explanation of the state hearing procedures:

What is a State Hearing?
If you think there has been a mistake or delay on your case, you may want to ask for a state hearing. You can ask for a hearing about actions by either the state department of human services or the local agency. Local agencies include the county department of human services (CDHS), the county child support enforcement agency (CSEA), and agencies under contract with them. A state hearing is a meeting with you, someone from the local agency, and a hearing officer from the Ohio Department of Human Services (ODHS). The person from the local agency will explain the action it has taken or wants to take on your case. Then you will have a chance to tell why you think it is wrong. The hearing officer will listen to you and to the local agency, and may ask questions to help bring out all the facts. The hearing officer will review the facts presented at the hearing, and recommend a decision based on whether or not the rules were correctly followed in your case.

How to ask for a Hearing

KEEP READING >>>

SEQ# 0000535 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000001
ODS 4002 (Rev. 3/99) HO: GRS NOTICE TYPE: HS01N1

To ask for a hearing, call or write your local agency or write to the Ohio Department of Human Services, State Hearings, 30 East Broad Street, 31st Floor, Columbus, Ohio 43266-0423. If you receive a notice about denying, reducing or stopping your assistance or services, fill out that form and mail it to State Hearings. You may also fax your hearing request to State Hearings at 1-614-728-9574. We must receive your hearing request within 90 days of the mailing date of the notice of action. However, if you receive food stamps, you may request a hearing on the amount of your food stamps at any time during your certification period. If someone else makes a written request for you, it must include a written statement, signed by you, telling us that person is your representative. Only you can make a request by telephone.

Continuing Assistance or Services

If you receive a notice that your assistance or services will be reduced, stopped, or restricted, the action will not be taken until the hearing is decided if we receive your hearing request within 15 days of the mailing date on the notice. In the food stamp program, your benefits will continue only until the end of your certification period. After that you must reapply and be found eligible. If your assistance or services have been changed without written notice, or if the change was made even though you requested a hearing, you can call the Bureau of State Hearings. If you need help doing this, call the appropriate ODHS district office, toll free at the following numbers: Canton, 1-800-686-1569; Cincinnati, 1-800-686-1571, Cleveland 1-800-686-1551; Columbus, 1-800-686-1568 and Toledo, 1-800-686-1572. If you do not know which district to call, ask your local agency. If your assistance is continuing and you lose the hearing, you may have to pay back any benefits that you were not eligible to receive. The continuing assistance provisions described in this section do not apply to the child support program. If you request a hearing about child support services, your hearing request will have no effect on your receipt of services while your hearing is pending.

County Conference

An informal meeting with a person from the local agency may settle the issue without the need for a state hearing. Often this is the quickest way to solve a problem. At this meeting your case will be reviewed with you. If a mistake has been made, it can be corrected without the need for a state hearing. You can set up a county conference by asking your caseworker. If you are not satisfied with the results, you can still have a state hearing. You do not have to have a county conference to have a state hearing. Asking for a county conference will not delay your state hearing.

When will the Hearing be Held?

After your request for a hearing is received, the bureau of state hearings will send you a notice giving the date, time, and place of the hearing. This notice will be sent to you at least 10 days before the hearing. The notice also will tell you what to do if you cannot come to the hearing as scheduled.

Where are Hearings Held?

Hearings are usually held at the local agency. If you are unable to go there, the hearing may be held some other place convenient to you and to the other people involved. If you want the hearing held somewhere other than the local agency, be sure to tell us that on your hearing request.

Postponement of the Hearing

If you cannot come to the hearing as scheduled, or if you need more time to prepare, you can ask the hearings section for a postponement. In the food stamp program postponement is limited to 30 days from the date of the first scheduled hearing. In all other programs, you must have a good reason to postpone the hearing.

If you do not Attend the Hearing

The Bureau of State Hearings will send you a dismissal notice if you don't come to the hearing. If you want to continue with your hearing request, you must contact the hearings section within 10 days and explain why you did not come to the hearing. The hearings section will decide whether you had a good reason. If you do not call within 10 days and show good cause, the hearing will be dismissed and you will lose the hearing. The local agency can then go ahead with the action it was planning to take. If you disagree with the dismissal, the dismissal notice will tell you how to ask for an administrative appeal.

Before the Hearing

You may have someone (lawyer, welfare rights worker, friend or relative) go to the hearing to present your case for you. If you are not going to be at the hearing, the person attending for you must bring a written

KEEP READING >>>

statement from you saying he or she is your representative. If you want legal help at the hearing, you must make arrangements before the hearing. Contact your local legal aid program to see if you qualify for free legal help. If you don't know how to reach your local legal aid office, call 1-800-589-5888, toll-free, for the local number. If you want notice of the hearing sent to your lawyer, you must give the hearings section your lawyer's name and address. You and your representative have the right to look at your file and the written rules being applied to your case. If your hearing is about work registration or employment and training, you may also look at your employment and training case file. You can get a free copy of any case record documents that are related to your hearing request. Any person acting for you must provide a signed statement from you before looking at your case record or getting copies of case record documents. The local agency does not have to show you confidential records, such as names of people who have given information against you, records of criminal proceedings, and certain medical records. Confidential records which you could not look at or question cannot be presented at the hearing or be used by the hearing officer in reaching a decision.

Subpoena
You can ask the hearing authority to subpoena documents or witnesses that would not otherwise be available and that are essential to your case. You must request the subpoena at least five calendar days before the date of the hearing and provide the name and the address of the person or document you want subpoenaed.

At the Hearing
You may bring witnesses, friends, relatives, or your lawyer to help you present your case. The hearing officer may limit the number of witnesses allowed in the hearing at any one time if there is not enough room. You and your representative will have the right to look at the evidence used at the hearing, present your side of the case without undue interference, ask questions, and bring papers or other evidence to support your case. The hearing will be tape recorded by the hearing officer so that the facts are taken down correctly. After the hearing decision is issued, you can get a free copy of the tape by contacting the hearings section. The hearing officer will listen to both sides but will not make a decision at the hearing. Instead, you will receive a written decision in the mail, issued by the hearing authority, a few weeks later.

Group Hearings
The hearings section may combine several individual hearing requests into a single group hearing, but only if there is no disagreement about the facts of each case and all involve related issues of state or federal law or county policy. The notice to schedule your hearing will tell you if you are scheduled for a group hearing. You or your representative will be allowed to present your own case individually and you will have the same rights at a group hearing as you would at an individual hearing.

After the Hearing
You should receive a hearing decision within 60 days of your hearing request if the hearing was only about food stamps, and within 90 days for all other programs. If you disagree with the hearing decision, your written decision will tell you how to ask for an administrative appeal.

Compliance with the Hearing Decision
If the hearing decision orders an increase in your food stamps, you should get the increase about 10 days after you get the hearing decision. If the decision orders a decrease in your food stamps, you should get the new, smaller amount the next time you regularly get food stamps. In all other programs, the agency must take the action ordered by the decision within 15 days of the date the decision is issued, but always within 90 days of your hearing request. Contact the bureau of state hearings if you have not promptly received the benefits awarded by the hearing decision.

Another Action Requires Another Hearing
If you receive another prior notice that says the local agency wants to change your assistance or services while you are waiting for a hearing or decision, you must ask for another hearing if you disagree with the new action. Remember, the fact that you are waiting for a hearing or decision will not stop another action from being taken on your case. You must ask for another hearing on the new action.

END

Client Notice: HS01N2

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number: 98198-05

Date Implemented: 11/16/99

Last Date Revised: 11/16/99

Description of Notice: This is a state hearing scheduling notice addressed to the CDHS.

Assistance Group(s): All

Hearing Rights: NO

Program ID: GCN252

Transaction ID:

Frequency: Daily

Volume (est. monthly): 1,500

Form Number: ODS 4002

Notes:

STATE HEARING SCHEDULING NOTICE

0000001
CLEVELAND DISTRICT OFFICE HEARINGS UNIT
615 W. SUPERIOR AVE., 9TH FLR.

CLEVELAND OH 44113-1882

ASHTABULA CDHS
2924 DONAHOE DR

ASHTABULA OH 44004-4540

		Assistance Group Name:	JANE DOE		
Mailing Date:	12/10/1999	Assistance Group Number:	9999999999	County: ASHTABULA	
Request Date:	12/03/1999	Program: OWF		Appeal Number:	9999999
Request Date:	12/03/1999	Program: PAF		Appeal Number:	9999999

We received your request for a state hearing. **Your hearing has been scheduled for:**

PLACE OF HEARING	**DATE OF HEARING**
ASHTABULA CDHS 2924 DONAHUE DR. ASHTABULA OH 44004-4596	SUNDAY DECEMBER 00, 1999
	TIME OF HEARING 09:30 AM

If you no longer want a hearing, or can't come to the hearing as scheduled, let us know right away. If you do not show up for your hearing, your case will be dismissed. Call the district hearing section at 1-800-686-1551 if you have questions about this hearing.

Below is an explanation of the state hearing procedures:

What is a State Hearing?
If you think there has been a mistake or delay on your case, you may want to ask for a state hearing. You can ask for a hearing about actions by either the state department of human services or the local agency. Local agencies include the county department of human services (CDHS), the county child support enforcement agency (CSEA), and agencies under contract with them. A state hearing is a meeting with you, someone from the local agency, and a hearing officer from the Ohio Department of Human Services (ODHS). The person from the local agency will explain the action it has taken or wants to take on your case. Then you will have a chance to tell why you think it is wrong. The hearing officer will listen to you and to the local agency, and may ask questions to help bring out all the facts. The hearing officer will review the facts presented at the hearing, and recommend a decision based on whether or not the rules were correctly followed in your case.

KEEP READING >>>

SEQ# 0000999 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000001
ODS 4002 (Rev. 3/99) HO: GNB NOTICE TYPE: HS01N2

How to ask for a Hearing

To ask for a hearing, call or write your local agency or write to the Ohio Department of Human Services, State Hearings, 30 East Broad Street, 31st Floor, Columbus, Ohio 43266-0423. If you receive a notice about denying, reducing or stopping your assistance or services, fill out that form and mail it to State Hearings. You may also fax your hearing request to State Hearings at 1-614-728-9574. We must receive your hearing request within 90 days of the mailing date of the notice of action. However, if you receive food stamps, you may request a hearing on the amount of your food stamps at any time during your certification period. If someone else makes a written request for you, it must include a written statement, signed by you, telling us that person is your representative. Only you can make a request by telephone.

Continuing Assistance or Services

If you receive a notice that your assistance or services will be reduced, stopped, or restricted, the action will not be taken until the hearing is decided if we receive your hearing request within 15 days of the mailing date on the notice. In the food stamp program, your benefits will continue only until the end of your certification period. After that you must reapply and be found eligible. If your assistance or services have been changed without written notice, or if the change was made even though you requested a hearing, you can call the Bureau of State Hearings. If you need help doing this, call the appropriate ODHS district office, toll free at the following numbers: Canton, 1-800-686-1569; Cincinnati, 1-800-686-1571, Cleveland 1-800-686-1551; Columbus, 1-800-686-1568 and Toledo, 1-800-686-1572. If you do not know which district to call, ask your local agency. If your assistance is continuing and you lose the hearing, you may have to pay back any benefits that you were not eligible to receive. The continuing assistance provisions described in this section do not apply to the child support program. If you request a hearing about child support services, your hearing request will have no effect on your receipt of services while your hearing is pending.

County Conference

An informal meeting with a person from the local agency may settle the issue without the need for a state hearing. Often this is the quickest way to solve a problem. At this meeting your case will be reviewed with you. If a mistake has been made, it can be corrected without the need for a state hearing. You can set up a county conference by asking your caseworker. If you are not satisfied with the results, you can still have a state hearing. You do not have to have a county conference to have a state hearing. Asking for a county conference will not delay your state hearing.

When will the Hearing be Held?

After your request for a hearing is received, the bureau of state hearings will send you a notice giving the date, time, and place of the hearing. This notice will be sent to you at least 10 days before the hearing. The notice also will tell you what to do if you cannot come to the hearing as scheduled.

Where are Hearings Held?

Hearings are usually held at the local agency. If you are unable to go there, the hearing may be held some other place convenient to you and to the other people involved. If you want the hearing held somewhere other than the local agency, be sure to tell us that on your hearing request.

This hearing will be conducted as a telephone hearing with the hearing officer participating by phone from his or her office. The appellant and representatives should be present at the location of the hearing indicated on the first page of this notice, at the scheduled time. You have the right to request a face-to-face hearing. To do so, you must call 1-800-686-1551 no later than three calendar days prior to the scheduled hearing date.

Postponement of the Hearing

If you cannot come to the hearing as scheduled, or if you need more time to prepare, you can ask the hearings section for a postponement. In the food stamp program postponement is limited to 30 days from the date of the first scheduled hearing. In all other programs, you must have a good reason to postpone the hearing.

If you do not Attend the Hearing

The Bureau of State Hearings will send you a dismissal notice if you don't come to the hearing. If you want to continue with your hearing request, you must contact the hearings section within 10 days and explain why you did not come to the hearing. The hearings section will decide whether you had a good reason. If you do not call within 10 days and show good cause, the hearing will be dismissed and you will lose the hearing.

KEEP READING >>>

The local agency can then go ahead with the action it was planning to take. If you disagree with the dismissal, the dismissal notice will tell you how to ask for an administrative appeal.

Before the Hearing
You may have someone (lawyer, welfare rights worker, friend or relative) go to the hearing to present your case for you. If you are not going to be at the hearing, the person attending for you must bring a written statement from you saying he or she is your representative. If you want legal help at the hearing, you must make arrangements before the hearing. Contact your local legal aid program to see if you qualify for free legal help. If you don't know how to reach your local legal aid office, call 1-800-589-5888, toll-free, for the local number. If you want notice of the hearing sent to your lawyer, you must give the hearings section your lawyer's name and address. You and your representative have the right to look at your file and the written rules being applied to your case. If your hearing is about work registration or employment and training, you may also look at your employment and training case file. You can get a free copy of any case record documents that are related to your hearing request. Any person acting for you must provide a signed statement from you before looking at your case record or getting copies of case record documents. The local agency does not have to show you confidential records, such as names of people who have given information against you, records of criminal proceedings, and certain medical records. Confidential records which you could not look at or question cannot be presented at the hearing or be used by the hearing officer in reaching a decision.

Subpoena
You can ask the hearing authority to subpoena documents or witnesses that would not otherwise be available and that are essential to your case. You must request the subpoena at least five calendar days before the date of the hearing and provide the name and the address of the person or document you want subpoenaed.

At the Hearing
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Group Hearings
The hearings section may combine several individual hearing requests into a single group hearing, but only if there is no disagreement about the facts of each case and all involve related issues of state or federal law or county policy. The notice to schedule your hearing will tell you if you are scheduled for a group hearing. You or your representative will be allowed to present your own case individually and you will have the same rights at a group hearing as you would at an individual hearing.

After the Hearing
You should receive a hearing decision within 60 days of your hearing request if the hearing was only about food stamps, and within 90 days for all other programs. If you disagree with the hearing decision, your written decision will tell you how to ask for an administrative appeal.

Compliance with the Hearing Decision
If the hearing decision orders an increase in your food stamps, you should get the increase about 10 days after you get the hearing decision. If the decision orders a decrease in your food stamps, you should get the new, smaller amount the next time you regularly get food stamps. In all other programs, the agency must take the action ordered by the decision within 15 days of the date the decision is issued, but always within 90 days of your hearing request. Contact the bureau of state hearings if you have not promptly received the benefits awarded by the hearing decision.

Another Action Requires Another Hearing
If you receive another prior notice that says the local agency wants to change your assistance or services

KEEP READING >>>

while you are waiting for a hearing or decision, you must ask for another hearing if you disagree with the new action. Remember, the fact that you are waiting for a hearing or decision will not stop another action from being taken on your case. You must ask for another hearing on the new action.

END

Client Notice: HS01N5

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number: 98198-05

Date Implemented: 11/16/99

Last Date Revised: 11/16/99

Description of Notice: This is a state hearing scheduling notice addressed to the agency representative.

Assistance Group(s): All

Hearing Rights: NO

Program ID: GCN252

Transaction ID:

Frequency: Daily

Volume (est. monthly): 500

Form Number: ODS 4002

Notes:

STATE HEARING SCHEDULING NOTICE

0000008
CLEVELAND DISTRICT OFFICE HEARINGS UNIT
615 W. SUPERIOR AVE., 9TH FLR.

CLEVELAND OH 44113-1882

JOHN DOE
DOE SMITH & JOHNSON
111 MAIN ST

ANYWHERE OH 99999-9999

Assistance Group Name: JANE DOE
Mailing Date: 12/10/1999 Assistance Group Number: 9999999999 County: SUMMIT
Request Date: 12/06/1999 Program: MED Appeal Number: 9999999

We received your request for a state hearing. **Your hearing has been scheduled for:**

PLACE OF HEARING	**DATE OF HEARING**
SUMMIT CDHS 37 N. HIGH ST. AKRON OH 44308-1991	SUNDAY DECEMBER 00, 1999
	TIME OF HEARING 11:30 AM

If you no longer want a hearing, or can't come to the hearing as scheduled, let us know right away. If you do not show up for your hearing, your case will be dismissed. Call the district hearing section at 1-800-686-1551 if you have questions about this hearing.

Below is an explanation of the state hearing procedures:

What is a State Hearing?
If you think there has been a mistake or delay on your case, you may want to ask for a state hearing. You can ask for a hearing about actions by either the state department of human services or the local agency. Local agencies include the county department of human services (CDHS), the county child support enforcement agency (CSEA), and agencies under contract with them. A state hearing is a meeting with you, someone from the local agency, and a hearing officer from the Ohio Department of Human Services (ODHS). The person from the local agency will explain the action it has taken or wants to take on your case. Then you will have a chance to tell why you think it is wrong. The hearing officer will listen to you and to the local agency, and may ask questions to help bring out all the facts. The hearing officer will review the facts presented at the hearing, and recommend a decision based on whether or not the rules were correctly followed in your case.

How to ask for a Hearing

KEEP READING >>>

To ask for a hearing, call or write your local agency or write to the Ohio Department of Human Services, State Hearings, 30 East Broad Street, 31st Floor, Columbus, Ohio 43266-0423. If you receive a notice about denying, reducing or stopping your assistance or services, fill out that form and mail it to State Hearings. You may also fax your hearing request to State Hearings at 1-614-728-9574. We must receive your hearing request within 90 days of the mailing date of the notice of action. However, if you receive food stamps, you may request a hearing on the amount of your food stamps at any time during your certification period. If someone else makes a written request for you, it must include a written statement, signed by you, telling us that person is your representative. Only you can make a request by telephone.

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If you receive a notice that your assistance or services will be reduced, stopped, or restricted, the action will not be taken until the hearing is decided if we receive your hearing request within 15 days of the mailing date on the notice. In the food stamp program, your benefits will continue only until the end of your certification period. After that you must reapply and be found eligible. If your assistance or services have been changed without written notice, or if the change was made even though you requested a hearing, you can call the Bureau of State Hearings. If you need help doing this, call the appropriate ODHS district office, toll free at the following numbers: Canton, 1-800-686-1569; Cincinnati, 1-800-686-1571, Cleveland 1-800-686-1551; Columbus, 1-800-686-1568 and Toledo, 1-800-686-1572. If you do not know which district to call, ask your local agency. If your assistance is continuing and you lose the hearing, you may have to pay back any benefits that you were not eligible to receive. The continuing assistance provisions described in this section do not apply to the child support program. If you request a hearing about child support services, your hearing request will have no effect on your receipt of services while your hearing is pending.

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When will the Hearing be Held?

After your request for a hearing is received, the bureau of state hearings will send you a notice giving the date, time, and place of the hearing. This notice will be sent to you at least 10 days before the hearing. The notice also will tell you what to do if you cannot come to the hearing as scheduled.

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This hearing will be conducted as a telephone hearing with the hearing officer participating by phone from his or her office. The appellant and representatives should be present at the location of the hearing indicated on the first page of this notice, at the scheduled time. You have the right to request a face-to-face hearing. To do so, you must call 1-800-686-1551 no later than three calendar days prior to the scheduled hearing date.

Postponement of the Hearing

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KEEP READING >>>

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Another Action Requires Another Hearing
If you receive another prior notice that says the local agency wants to change your assistance or services while you are waiting for a hearing or decision, you must ask for another hearing if you disagree with the

KEEP READING >>>

new action. Remember, the fact that you are waiting for a hearing or decision will not stop another action from being taken on your case. You must ask for another hearing on the new action.

END

Client Notice: HS02N1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number: 98198-05

Date Implemented: 11/16/99

Last Date Revised: 11/16/99

Description of Notice: This is a state hearing dismissal notice (hearing request denied) addressed to the appellant.

Assistance Group(s): All

Hearing Rights: NO

Program ID: GCN252

Transaction ID:

Frequency: Daily

Volume (est. monthly): 30

Form Number: ODS 4002

Notes:

STATE HEARING DISMISSAL NOTICE

0000038
CANTON DISTRICT OFFICE HEARINGS UNIT
401 MARKET AVE. NORTH, THIRD F

CANTON OH 44702-1543

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 12/16/1999
Request Date: 12/09/1999

Assistance Group Name: JANE DOE
Assistance Group Number: 9999999999 County: STARK
Program: MED Appeal Number: 9999999

Your state hearing request is denied because:

You are not the applicant or recipient, nor did you provide written authorization from the applicant or recipient allowing you to act as representative.

If you believe that we do not understand your situation, you may submit another request, with additional information explaining you situation to:

Hearing Section	Address	Telephone Number
CANTON	401 MARKET AVE. NORTH, THIRD FL. CANTON OH 44702-1543	1-800-686-1569

Important Notice: If you have tried to explain your situation to the district hearings section and still disagree with their decision, you may request an administrative appeal by writing to: Ohio Department of Human Services, Office of Legal Services, 30 East Broad Street, 31st floor, Columbus, Ohio 43266-0423. Your request should include a copy of this notice and the reason you think it is wrong. Your written request must be received by the Office of Leagal Services within 15 calendar days from the mailing date of this notice. (if the 15th day falls on weekend or holiday this dead line is extended to next work day.)

Unless you request an administrative appeal, a dismissal is a final and binding decision on your request for state hearing . If assistance or services are continuing because of a timely hearing request, the dismissal of your request allows the local agency to take the proposed action.

If you want information on free legal service, but don't know the number of local legal aid office, you may call the Ohio State Legal Services Association, toll free, at 1-800-589-5888, for the local number.

Distribution: original to appellant, one copy to Bureau of State Hearings, one copy to local agency, one copy to district hearings section. (Photo copy to appellant's authorized representative, if any, and ODHS units as appropriate)

END

SEQ# 0000030
ODS 4000 (Rev. 3/99)

THIS SPACE FOR OFFICIAL USE ONLY

PRINT SEQ. 0000038
HO: NOTICE TYPE: HS02N1

Client Notice: HS02N2

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number: 98198-05

Date Implemented: 11/16/99

Last Date Revised: 11/16/99

Description of Notice: This is a state hearing dismissal notice (hearing request denied) addressed to the CDHS.

Assistance Group(s): All

Hearing Rights: NO

Program ID: GCN252

Transaction ID:

Frequency: Daily

Volume (est. monthly): 30

Form Number: ODS 4002

Notes:

STATE HEARING DISMISSAL NOTICE

0000099
TOLEDO DISTRICT OFFICE HEARINGS UNIT
ONE GOVERNMENT CTR., RM. 913

TOLEDO OH 43604-2239

WOOD CDHS
1928 E GYPSY LANE RD
P.O. BOX 679
BOWLING GREEN OH 43402-9396

Assistance Group Name: JANE DOE
Mailing Date: 12/15/1999 Assistance Group Number: 9999999999 County: WOOD
Request Date: 12/02/1999 Program: MED Appeal Number: 9999999

Your state hearing request is denied because:

The issue of your request is not appealable to state hearing.

If you believe that we do not understand your situation, you may submit another request, with additional information explaining you situation to:

Hearing Section	Address	Telephone Number
TOLEDO	ONE GOVERNMENT CTR., RM. 913 TOLEDO OH 43604-2239	1-800-686-1572

Important Notice: If you have tried to explain your situation to the district hearings section and still disagree with their decision, you may request an administrative appeal by writing to: Ohio Department of Human Services, Office of Legal Services, 30 East Broad Street, 31st floor, Columbus, Ohio 43266-0423. Your request should include a copy of this notice and the reason you think it is wrong. Your written request must be received by the Office of Leagal Services within 15 calendar days from the mailing date of this notice. (if the 15th day falls on weekend or holiday this dead line is extended to next work day.)

Unless you request an administrative appeal, a dismissal is a final and binding decision on your request for state hearing . If assistance or services are continuing because of a timely hearing request, the dismissal of your request allows the local agency to take the proposed action.

If you want information on free legal service, but don't know the number of local legal aid office, you may call the Ohio State Legal Services Association, toll free, at 1-800-589-5888, for the local number.

Distribution: original to appellant, one copy to Bureau of State Hearings, one copy to local agency, one copy to district hearings section. (Photo copy to appellant's authorized representative, if any, and ODHS units as appropriate)

END

SEQ# 0000002 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000099
ODS 4000 (Rev. 3/99) HO: NOTICE TYPE: HS02N2

Client Notice: HS02N5

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number: 98198-05

Date Implemented: 11/16/99

Last Date Revised: 11/16/99

Description of Notice: This is a state hearing dismissal notice (hearing request denied) addressed to the agency representative.

Assistance Group(s): All

Hearing Rights: NO

Program ID: GCN252

Transaction ID:

Frequency: Daily

Volume (est. monthly): 5

Form Number: ODS 4002

Notes:

STATE HEARING DISMISSAL NOTICE

0000108
CINCINNATI DISTRICT OFFICE HEARINGS UNIT
100 E. EIGHTH ST., 4TH FLR.

CINCINNATI OH 45202-2194

JANE DOE
PACT UNIT
65 E STATE ST STE 405

COLUMBUS OH 43215-4213

Assistance Group Name: JANE DOE
Mailing Date: 01/07/2000 Assistance Group Number: 9999999999 County: HAMILTON
Request Date: 11/19/1999 Program: MED Appeal Number: 9999999

Your state hearing request is denied because:

Your appeal is not timely. The hearing notice was mailed 00/00/0000 and the 90th day was 00/00/0000.

If you believe that we do not understand your situation, you may submit another request, with additional information explaining you situation to:

Hearing Section	Address	Telephone Number
CINCINNATI	100 E. EIGHTH ST., 4TH FLR. CINCINNATI OH 45202-2194	1-800-686-1571

Important Notice: If you have tried to explain your situation to the district hearings section and still disagree with their decision, you may request an administrative appeal by writing to: Ohio Department of Human Services, Office of Legal Services, 30 East Broad Street, 31st floor, Columbus, Ohio 43266-0423. Your request should include a copy of this notice and the reason you think it is wrong. Your written request must be received by the Office of Leagal Services within 15 calendar days from the mailing date of this notice. (if the 15th day falls on weekend or holiday this dead line is extended to next work day.)

Unless you request an administrative appeal, a dismissal is a final and binding decision on your request for state hearing . If assistance or services are continuing because of a timely hearing request, the dismissal of your request allows the local agency to take the proposed action.

If you want information on free legal service, but don't know the number of local legal aid office, you may call the Ohio State Legal Services Association, toll free, at 1-800-589-5888, for the local number.

Distribution: original to appellant, one copy to Bureau of State Hearings, one copy to local agency, one copy to district hearings section. (Photo copy to appellant's authorized representative, if any, and ODHS units as appropriate)

END

SEQ# 0000010 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000108
ODS 4000 (Rev. 3/99) HO: NOTICE TYPE: HS02N5

Client Notice: HS03N1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number: 98198-05

Date Implemented: 11/16/99

Last Date Revised: 11/16/99

Description of Notice: This is a state hearing request dismissal notice (hearing request withdrawn in writing) addressed to the appellant.

Assistance Group(s): All

Hearing Rights: NO

Program ID: GCN252

Transaction ID:

Frequency: Daily

Volume (est. monthly): 300

Form Number: ODS 4002

Notes:

STATE HEARING DISMISSAL NOTICE

0000015
COLUMBUS DISTRICT OFFICE HEARINGS UNIT
899 E. BROAD ST., 4TH FLR.

COLUMBUS OH 43205-1190

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

		Assistance Group Name:	JANE DOE		
Mailing Date:	12/10/1999	Assistance Group Number:	9999999999	County: FRANKLIN	
Request Date:	11/04/1999	Program: FS		Appeal Number:	9999999
Request Date:	11/04/1999	Program: MED		Appeal Number:	9999999
Request Date:	11/04/1999	Program: MED		Appeal Number:	9999999

Your state hearing request is dismissed because you withdrew your request in writing.

Important Notice: If you have tried to explain your situation to the district hearing section and still disagree with their decision, you may request an administrative appeal by writing to: Ohio Department of Human Services, Office of Legal Services, 30 East Broad Street, 31st floor, Columbus, Ohio 43266-0423. Your request should include a copy of this notice and the reason you think it is wrong. Your written request must be received by the Office of Legal Services within 15 calendar days from the mailing date of this notice (if the 15th day falls on a weekend or holiday, this deadline is extended to the next work day.)

Unless you request an administrative appeal, a dismissal is a final and binding decision on your request for state hearing. If assistance or services are continuing because of a timely hearing request, the dismissal of your request allows the local agency to take appropriate action.

If you want information on free legal services. but do not know the number of the local legal aid office, you may call The Ohio State Legal Services Association toll free, at 1-800-689-5888 for the local number.

Distribution: original to appellant, one copy to Bureau of State Hearings, one copy to the local agency abd one copy to the district hearings section. (Photo copy to appellant's authorized representative, if anyt, and ODHS units as appropriate.)

END

SEQ# 0000129
ODS 4000 (Rev. 3/99)

THIS SPACE FOR OFFICIAL USE ONLY

PRINT SEQ. 0000015
HO: GRS NOTICE TYPE: HS03N1

Client Notice: HS03N2

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number: 98198-05

Date Implemented: 11/16/99

Last Date Revised: 11/16/99

Description of Notice: This is a state hearing dismissal notice (hearing request withdrawn in writing) addressed to the CDHS.

Assistance Group(s): All

Hearing Rights: NO

Program ID: GCN252

Transaction ID:

Frequency: Daily

Volume (est. monthly): 300

Form Number: ODS 4002

Notes:

STATE HEARING DISMISSAL NOTICE

0000003
CINCINNATI DISTRICT OFFICE HEARINGS UNIT
100 E. EIGHTH ST., 4TH FLR.

CINCINNATI OH 45202-2194

CLARK CDHS
1345 LAGONDA AVE

SPRINGFIELD OH 45503-4001

		Assistance Group Name:	JANE DOE		
Mailing Date:	12/15/1999	Assistance Group Number:	9999999999	County: CLARK	
Request Date:	11/12/1999	Program: OWF		Appeal Number:	9999999
Request Date:	11/12/1999	Program: FS		Appeal Number:	9999999
Request Date:	11/12/1999	Program: MED		Appeal Number:	9999999
Request Date:	11/12/1999	Program: MED		Appeal Number:	9999999

Your state hearing request is dismissed because you withdrew your request in writing.

Important Notice: If you have tried to explain your situation to the district hearing section and still disagree with their decision, you may request an administrative appeal by writing to: Ohio Department of Human Services, Office of Legal Services, 30 East Broad Street, 31st floor, Columbus, Ohio 43266-0423. Your request should include a copy of this notice and the reason you think it is wrong. Your written request must be received by the Office of Legal Services within 15 calendar days from the mailing date of this notice (if the 15th day falls on a weekend or holiday, this deadline is extended to the next work day.)

Unless you request an administrative appeal, a dismissal is a final and binding decision on your request for state hearing. If assistance or services are continuing because of a timely hearing request, the dismissal of your request allows the local agency to take appropriate action.

If you want information on free legal services. but do not know the number of the local legal aid office, you may call The Ohio State Legal Services Association toll free, at 1-800-689-5888 for the local number.

Distribution: original to appellant, one copy to Bureau of State Hearings, one copy to the local agency abd one copy to the district hearings section. (Photo copy to appellant's authorized representative, if anyt, and ODHS units as appropriate.)

END

SEQ# 0000014
ODS 4000 (Rev. 3/99)

THIS SPACE FOR OFFICIAL USE ONLY

PRINT SEQ. 0000003
HO: WRY NOTICE TYPE: HS03N2

Client Notice: HS03N5

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number: 98198-05

Date Implemented: 11/16/99

Last Date Revised: 11/16/99

Description of Notice: This is a state hearing dismissal notice (hearing request withdrawn in writing) addressed to the agency representative.

Assistance Group(s): All

Hearing Rights: NO

Program ID: GCN252

Transaction ID:

Frequency: Daily

Volume (est. monthly): 5

Form Number: ODS 4002

Notes:

STATE HEARING DISMISSAL NOTICE

0000004
COLUMBUS DISTRICT OFFICE HEARINGS UNIT
899 E. BROAD ST., 4TH FLR.

COLUMBUS OH 43205-1190

JANE DOE
BUREAU OF COMMUNITY SERVICES
30 EAST BROAD STREET
27TH FLOOR
COLUMBUS OH 43266

		Assistance Group Name:	JANE DOE		
Mailing Date:	12/14/1999	Assistance Group Number:	9999999999	County:	DELAWARE
Request Date:	10/04/1999	Program: MED		Appeal Number:	9999999

Your state hearing request is dismissed because you withdrew your request in writing.

Important Notice: If you have tried to explain your situation to the district hearing section and still disagree with their decision, you may request an administrative appeal by writing to: Ohio Department of Human Services, Office of Legal Services, 30 East Broad Street, 31st floor, Columbus, Ohio 43266-0423. Your request should include a copy of this notice and the reason you think it is wrong. Your written request must be received by the Office of Legal Services within 15 calendar days from the mailing date of this notice (if the 15th day falls on a weekend or holiday, this deadline is extended to the next work day.)

Unless you request an administrative appeal, a dismissal is a final and binding decision on your request for state hearing. If assistance or services are continuing because of a timely hearing request, the dismissal of your request allows the local agency to take appropriate action.

If you want information on free legal services. but do not know the number of the local legal aid office, you may call The Ohio State Legal Services Association toll free, at 1-800-689-5888 for the local number.

Distribution: original to appellant, one copy to Bureau of State Hearings, one copy to the local agency abd one copy to the district hearings section. (Photo copy to appellant's authorized representative, if anyt, and ODHS units as appropriate.)

END

SEQ# 0000010
ODS 4000 (Rev. 3/99)

THIS SPACE FOR OFFICIAL USE ONLY

PRINT SEQ. 0000004
HO: LJH NOTICE TYPE: HS03N5

Client Notice: HS04N1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number: 98198-05

Date Implemented: 11/16/99

Last Date Revised: 11/16/99

Description of Notice: This is a state hearing dismissal notice (appellant or representative did not show at the scheduled time) addressed to the appellant.

Assistance Group(s): All

Hearing Rights: NO

Program ID: GCN252

Transaction ID:

Frequency: Daily

Volume (est. monthly): 600

Form Number: ODS 4002

Notes:

STATE HEARING DISMISSAL NOTICE

0000018
COLUMBUS DISTRICT OFFICE HEARINGS UNIT
899 E. BROAD ST., 4TH FLR.

COLUMBUS OH 43205-1190

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Assistance Group Name: JANE DOE
Mailing Date: 12/10/1999 Assistance Group Number: 9999999999 County: FRANKLIN
Request Date: 11/17/1999 Program: MED Appeal Number: 9999999

Your state hearing request will be dismissed as abandoned because you or your authorized representative did not come to the hearing scheduled for 12/07/1999. If you want the hearing rescheduled, you must contact the assigned hearing section by telephone or by completing this form and returning it to:

Hearing Section	Address	Telephone Number
COLUMBUS	899 E. BROAD ST., 4TH FLR. COLUMBUS OH 43205-1190	1-800-686-1568

Your request for rescheduling must be received by 12/20/1999. A hearing will be rescheduled only if you had a good reason for not coming to your hearing. The hearing authority will decide if you had a good reason.

I want my hearing rescheduled. I did not come to the hearing because (use this space to explain why.)

_____

_____

_____

Important Notice: If you have tried to explain your situation to the district hearings section and still disagree with their decision, you may request an administrative appeal by writing to: Ohio Department of Human Services, Office of Legal Services, 30 East Broad Street, 31st floor, Columbus, Ohio 43266-0423. Your request should include a copy of this notice and the reason you think it is wrong. Your written request must be received by the Office of Leagal Services within 15 calendar days from the mailing date of this notice. (if the 15th day falls on weekend or holiday this dead line is extended to next work day.)

KEEP READING >>>

SEQ# 0000117 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000018
ODS 4000 (Rev. 3/99) HO: GRS NOTICE TYPE: HS04N1

Unless you request an administrative appeal, a dismissal is a final and binding decision on your request for state hearing . If assistance or services are continuing because of a timely hearing request, the dismissal of your request allows the local agency to take the proposed action.

If you want information on free legal service, but don't know the number of local legal aid office, you may call the Ohio State Legal Services Association, toll free, at 1-800-589-5888, for the local number.

Distribution: original to appellant, one copy to Bureau of State Hearings, one copy to local agency, one copy to district hearings section. (Photo copy to appellant's authorized representative, if any, and ODHS units as appropriate)

END

Client Notice: HS04N2

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number: 98198-05

Date Implemented: 11/16/99

Last Date Revised: 11/16/99

Description of Notice: This is a state hearing dismissal notice (appellant or representative did not show at scheduled time) addressed to the CDHS.

Assistance Group(s): All

Hearing Rights: NO

Program ID: GCN252

Transaction ID:

Frequency: Daily

Volume (est. monthly): 600

Form Number: ODS 4002

Notes:

STATE HEARING DISMISSAL NOTICE

0000001
TOLEDO DISTRICT OFFICE HEARINGS UNIT
ONE GOVERNMENT CTR., RM. 913

TOLEDO OH 43604-2239

ALLEN CDHS
550 WEST ELM STREET
PO BX 4506
LIMA OH 45802-4506

Mailing Date: 12/15/1999
Request Date: 11/10/1999

Assistance Group Name: JOHN DOE
Assistance Group Number: 9999999999 County: ALLEN
Program: OWF Appeal Number: 9999999

Your state hearing request will be dismissed as abandoned because you or your authorized representative did not come to the hearing scheduled for 12/07/1999. If you want the hearing rescheduled, you must contact the assigned hearing section by telephone or by completing this form and returning it to:

Hearing Section	Address	Telephone Number
TOLEDO	ONE GOVERNMENT CTR., RM. 913 TOLEDO OH 43604-2239	1-800-686-1572

Your request for rescheduling must be received by 12/27/1999. A hearing will be rescheduled only if you had a good reason for not coming to your hearing. The hearing authority will decide if you had a good reason.

I want my hearing rescheduled. I did not come to the hearing because (use this space to explain why.)

_____

_____

_____

Important Notice: If you have tried to explain your situation to the district hearings section and still disagree with their decision, you may request an administrative appeal by writing to: Ohio Department of Human Services, Office of Legal Services, 30 East Broad Street, 31st floor, Columbus, Ohio 43266-0423. Your request should include a copy of this notice and the reason you think it is wrong. Your written request must be received by the Office of Leagal Services within 15 calendar days from the mailing date of this notice. (if the 15th day falls on weekend or holiday this dead line is extended to next work day.)

KEEP READING >>>

SEQ# 0000027
ODS 4000 (Rev. 3/99)

THIS SPACE FOR OFFICIAL USE ONLY

PRINT SEQ. 0000001
HO: JLH NOTICE TYPE: HS04N2

Unless you request an administrative appeal, a dismissal is a final and binding decision on your request for state hearing . If assistance or services are continuing because of a timely hearing request, the dismissal of your request allows the local agency to take the proposed action.

If you want information on free legal service, but don't know the number of local legal aid office, you may call the Ohio State Legal Services Association, toll free, at 1-800-589-5888, for the local number.

Distribution: original to appellant, one copy to Bureau of State Hearings, one copy to local agency, one copy to district hearings section. (Photo copy to appellant's authorized representative, if any, and ODHS units as appropriate)

END

Client Notice: HS04N5

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number: 98198-05

Date Implemented: 11/16/99

Last Date Revised: 11/16/99

Description of Notice: This is a state hearing dismissal notice (appellant or representative did not show at the scheduled time) addressed to the agency representative.

Assistance Group(s): All

Hearing Rights: NO

Program ID: GCN252

Transaction ID:

Frequency: Daily

Volume (est. monthly): 100

Form Number: ODS 4002

Notes:

STATE HEARING DISMISSAL NOTICE

0000059
CINCINNATI DISTRICT OFFICE HEARINGS UNIT
100 E. EIGHTH ST., 4TH FLR.

CINCINNATI OH 45202-2194

JANE DOE
BUREAU OF COMMUNITY SERVICES
30 EAST BROAD STREET
27TH FLOOR
COLUMBUS OH 43266

Assistance Group Name: JOHN DOE
Mailing Date: 12/10/1999 Assistance Group Number: 9999999999 County: HAMILTON
Request Date: 10/27/1999 Program: MED Appeal Number: 9999999

Your state hearing request will be dismissed as abandoned because you or your authorized representative did not come to the hearing scheduled for 12/08/1999. If you want the hearing rescheduled, you must contact the assigned hearing section by telephone or by completing this form and returning it to:

Hearing Section	Address	Telephone Number
CINCINNATI	100 E. EIGHTH ST., 4TH FLR. CINCINNATI OH 45202-2194	1-800-686-1571

Your request for rescheduling must be received by 12/20/1999. A hearing will be rescheduled only if you had a good reason for not coming to your hearing. The hearing authority will decide if you had a good reason.

I want my hearing rescheduled. I did not come to the hearing because (use this space to explain why.)

_____

_____

_____

Important Notice: If you have tried to explain your situation to the district hearings section and still disagree with their decision, you may request an administrative appeal by writing to: Ohio Department of Human Services, Office of Legal Services, 30 East Broad Street, 31st floor, Columbus, Ohio 43266-0423. Your request should include a copy of this notice and the reason you think it is wrong. Your written request must be received by the Office of Leagal Services within 15 calendar days from the mailing date of this notice. (if the 15th day falls on weekend or holiday this dead line is extended to next work day.)

KEEP READING >>>

SEQ# 0000100 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000059
ODS 4000 (Rev. 3/99) HO: PJS NOTICE TYPE: HS04N5

Unless you request an administrative appeal, a dismissal is a final and binding decision on your request for state hearing . If assistance or services are continuing because of a timely hearing request, the dismissal of your request allows the local agency to take the proposed action.

If you want information on free legal service, but don't know the number of local legal aid office, you may call the Ohio State Legal Services Association, toll free, at 1-800-589-5888, for the local number.

Distribution: original to appellant, one copy to Bureau of State Hearings, one copy to local agency, one copy to district hearings section. (Photo copy to appellant's authorized representative, if any, and ODHS units as appropriate)

END

Client Notice: MC01-C1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	December, 1996

Description of Notice:	Notice of right to state hearing - change in law or policy; No benefit change resulting from GA/DA implementation. Will not be generated any more.
Assistance Categories:	All AGs except FS, MAM, MAG, MAMP, MAGP
Hearing Rights:	Yes
Program ID:	GMC020
Transaction ID:	MC020
Frequency:	Per request
Volume (est. monthly):	0
Form Number:	DHS 8523

Notes:

WFAX 2149

IMPORTANT NOTICE

CUYAHOGA COUNTY DEPT OF HUMAN SERVICES
KAPPLE GREENS 2100
1221 ST CLAIR AVE
KLEAVLIN OH 441080000

As of 06/01/1998 you have used 04 months of your initial 36 months of Ohio Works First benefit eligibility. If you continue to be eligible, you have 32 months remaining. After you have used up your 36 months, you might be eligible for additional months. See your caseworker.

JANE DOE
111 MAIN ST.

ANYWHERE, USA 11111-1111

Mailing Date: 06/02/1998
From: JANE DOE
Phone: (301) 777-9311 Ext: 1111

Worker ID: WFAX00
Case Number: 1000000000
AG Name: JANE DOE

Dear JANE DOE

Your DISABILITY ASSISTANCE (DA) benefits will CONTINUE with no change.

The following individuals are members of this assistance group:
JANE D (INELIGIBLE)

REASON:
The regulation supporting this action is contained in Section

GA A 1 C1

KEEP READING >>>

SEQ# 0009000 THIS SPACE FOR OFFICIAL USE ONLY
DHS 8523 (Rev. 12/96) 1000000000/GA A/01 NOTICE TYPE: MC01C1

AG Name:	Case Number:	Mailing Date:
JANE DOE	1000000000	06/02/1998

YOUR RIGHT TO A STATE HEARING

This notice is to tell you about action we are taking on your case. If you do not understand this action, you should contact your caseworker. After talking to your caseworker, it is possible that we will change our decision or that you will agree with the action.

IF YOU BELIEVE THE NEW LAW OR POLICY HAS BEEN INCORRECTLY APPLIED TO YOUR CASE, YOU HAVE THE RIGHT TO A STATE HEARING. A state hearing lets you or your representative (lawyer, welfare rights worker, friend or relative) give your reasons against the action. We will also attend the hearing to present our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

If you want a hearing we must receive your hearing request within 90 days of the mailing date on this notice.

If someone else makes a written hearing request for you, it must include a written statement, signed by you, telling us that person is your representative. Only you can make a request by telephone.

If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association, toll free a 1-(800)-589-5888, for the local number.

If you want a state hearing, check the appropriate box below, sign and date this form and send ALL PAGES to the Ohio Department of Human Services, State Hearings, 30 East Broad Street, 31st floor, Columbus, Ohio 43266-0423.

☐ I want a county conference and a state hearing.

☐ I want a state hearing only.

I want a hearing.

SIGNATURE	DATE	TELEPHONE NUMBER

END

Client Notice: MC01-I1

A client notice name is composed of th **Notice Type**, which is four characters and a n**Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	December, 1996

Description of Notice:	Notice Of Benefit increase due to a - Change In Law Or Policy.
Assistance Categories:	All AGs except MAA, MAAP, MAB, MABP, MAD, MADP, MAM, MAG, MAMP, MAGP
Hearing Rights:	Yes
Program ID:	GMC020
Transaction ID:	MC020
Frequency:	Per request
Volume (est. monthly):	1
Form Number:	DHS 8523
Notes:	

WFAX 2149

IMPORTANT NOTICE

CUYAHOGA COUNTY DEPT OF HUMAN SERVICES
KAPPLE GREENS 2100
1221 ST CLAIR AVE
KLEAVLIN OH 441080000

As of 06/01/1998 you have used 04 months of your initial 36 months of Ohio Works First benefit eligibility. If you continue to be eligible, you have 32 months remaining. After you have used up your 36 months, you might be eligible for additional months. See your caseworker.

JOHN DOE
111 MAIN ST.

ANYWHERE, USA 11111-1111

Mailing Date: 06/02/1998
From: JANE DOE
Phone: (301) 777-9311 Ext: 1111

Worker ID: WFAX00
Case Number: 2000000000
AG Name: JOHN DOE

Dear JOHN DOE

Your DISABILITY ASSISTANCE (DA) benefits will be INCREASED from $0.00 to $0.00 effective 06/01/1998.

The following individuals are members of this assistance group:
JANE D (INELIGIBLE)

REASON:
The regulation supporting this action is contained in Section

GA A 1 I1

KEEP READING >>>

SEQ# 0009100 THIS SPACE FOR OFFICIAL USE ONLY
DHS 8523 (Rev. 12/96) 2000000000/GA A/01 NOTICE TYPE: MC01I1

AG Name:	Case Number:	Mailing Date:
JOHN DOE	2000000000	06/02/1998

YOUR RIGHT TO A STATE HEARING

This notice is to tell you about action we are taking on your case. If you do not understand this action, you should contact your caseworker. After talking to your caseworker, it is possible that we will change our decision or that you will agree with the action.

IF YOU BELIEVE THE NEW LAW OR POLICY HAS BEEN INCORRECTLY APPLIED TO YOUR CASE, YOU HAVE THE RIGHT TO A STATE HEARING. A state hearing lets you or your representative (lawyer, welfare rights worker, friend or relative) give your reasons against the action. We will also attend the hearing to present our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

If you want a hearing we must receive your hearing request within 90 days of the mailing date on this notice.

If someone else makes a written hearing request for you, it must include a written statement, signed by you, telling us that person is your representative. Only you can make a request by telephone.

If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association, toll free a 1-(800)-589-5888, for the local number.

If you want a state hearing, check the appropriate box below, sign and date this form and send ALL PAGES to the Ohio Department of Human Services, State Hearings, 30 East Broad Street, 31st floor, Columbus, Ohio 43266-0423.

☐ I want a county conference and a state hearing.

☐ I want a state hearing only.

I want a hearing.

SIGNATURE	DATE	TELEPHONE NUMBER

END

Client Notice: MC01-I2

A client notice name is composed of th **Notice Type**, which is four characters and a n**Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	December, 1996

Description of Notice:	Decrease in spenddown liability due to a change in law or policy.
Assistance Categories:	MAA, MAB, MAD AGs only
Hearing Rights:	Yes
Program ID:	GMC020
Transaction ID:	MC020
Frequency:	Per request
Volume (est. monthly):	
Form Number:	DHS 8523
Notes:	

WFAX 2149

IMPORTANT NOTICE

CUYAHOGA COUNTY DEPT OF HUMAN SERVICES
KAPPLE GREENS 2100
1221 ST CLAIR AVE
KLEAVLIN OH 441080000

As of 06/01/1998 you have used 04 months of your initial 36 months of Ohio Works First benefit eligibility. If you continue to be eligible, you have 32 months remaining. After you have used up your 36 months, you might be eligible for additional months. See your caseworker.

JOHN DOE
111 MAIN ST.

ANYWHERE, USA 11111-1111

Mailing Date: 06/02/1998
From: JANE DOE
Phone: (301) 777-9311 Ext: 1111

Worker ID: WFAX00
Case Number: 3000000000
AG Name: JOHN DOE

Dear JHON DOE

Your DISABILITY ASSISTANCE (DA) Spenddown liability will be DECREASED from $0.00 to $0.00 effective 06/01/1998.

The following individuals are members of this assistance group:
JANE D (INELIGIBLE)

REASON:
The regulation supporting this action is contained in Section

GA A 1 I2

KEEP READING >>>

SEQ# 0009200 THIS SPACE FOR OFFICIAL USE ONLY
DHS 8523 (Rev. 12/96) 3000000000/GA A/01 NOTICE TYPE: MC01I2

AG Name:	Case Number:	Mailing Date:
JOHN DOE	3000000000	06/02/1998

YOUR RIGHT TO A STATE HEARING

This notice is to tell you about action we are taking on your case. If you do not understand this action, you should contact your caseworker. After talking to your caseworker, it is possible that we will change our decision or that you will agree with the action.

IF YOU BELIEVE THE NEW LAW OR POLICY HAS BEEN INCORRECTLY APPLIED TO YOUR CASE, YOU HAVE THE RIGHT TO A STATE HEARING. A state hearing lets you or your representative (lawyer, welfare rights worker, friend or relative) give your reasons against the action. We will also attend the hearing to present our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

If you want a hearing we must receive your hearing request within 90 days of the mailing date on this notice.

If someone else makes a written hearing request for you, it must include a written statement, signed by you, telling us that person is your representative. Only you can make a request by telephone.

If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association, toll free a 1-(800)-589-5888, for the local number.

If you want a state hearing, check the appropriate box below, sign and date this form and send ALL PAGES to the Ohio Department of Human Services, State Hearings, 30 East Broad Street, 31st floor, Columbus, Ohio 43266-0423.

☐ I want a county conference and a state hearing.

☐ I want a state hearing only.

I want a hearing.

SIGNATURE	DATE	TELEPHONE NUMBER

END

Client Notice: MC01-I3

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	December, 1996

Description of Notice:	Decrease in patient liability due toa change in law or policy.
Assistance Categories:	MAA, MAB, MAD AGs only
Hearing Rights:	Yes
Program ID:	GMC020
Transaction ID:	MC020
Frequency:	Per Request
Volume (est. monthly):	
Form Number:	DHS 8523
Notes:	

WFAX 2149

IMPORTANT NOTICE

CUYAHOGA COUNTY DEPT OF HUMAN SERVICES
KAPPLE GREENS 2100
1221 ST CLAIR AVE
KLEAVLIN OH 441080000

As of 06/01/1998 you have used 04 months of your initial 36 months of Ohio Works First benefit eligibility. If you continue to be eligible, you have 32 months remaining. After you have used up your 36 months, you might be eligible for additional months. See your caseworker.

JOHN DOE
111 MAIN ST.

ANYWHERE, USA 11111-1111

Mailing Date: 08/02/1996
From: JANE DOE
Phone: (301) 777-9311 Ext: 1111

Worker ID: WFAX00
Case Number: 4000000000
AG Name: JOHN DOE

Dear JOHN DOE

Your DISABILITY ASSISTANCE (DA) patient liability will be DECREASED from $0.00 to $0.00 effective 06/01/1998.

The following individuals are members of this assistance group:
JANE D (INELIGIBLE)

REASON:
The regulation supporting this action is contained in Section

GA A 1 I3

KEEP READING >>>

SEQ# 0009300 THIS SPACE FOR OFFICIAL USE ONLY
DHS 8523 (Rev. 12/96) 4000000000/GA A/01 NOTICE TYPE: MC01I3

AG Name:	Case Number:	Mailing Date:
JOHN DOE	4000000000	08/02/1996

YOUR RIGHT TO A STATE HEARING

This notice is to tell you about action we are taking on your case. If you do not understand this action, you should contact your caseworker. After talking to your caseworker, it is possible that we will change our decision or that you will agree with the action.

IF YOU BELIEVE THE NEW LAW OR POLICY HAS BEEN INCORRECTLY APPLIED TO YOUR CASE, YOU HAVE THE RIGHT TO A STATE HEARING. A state hearing lets you or your representative (lawyer, welfare rights worker, friend or relative) give your reasons against the action. We will also attend the hearing to present our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

If you want a hearing we must receive your hearing request within 90 days of the mailing date on this notice.

If someone else makes a written hearing request for you, it must include a written statement, signed by you, telling us that person is your representative. Only you can make a request by telephone.

If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association, toll free a 1-(800)-589-5888, for the local number.

If you want a state hearing, check the appropriate box below, sign and date this form and send ALL PAGES to the Ohio Department of Human Services, State Hearings, 30 East Broad Street, 31st floor, Columbus, Ohio 43266-0423.

☐ I want a county conference and a state hearing.

☐ I want a state hearing only.

I want a hearing.

SIGNATURE	DATE	TELEPHONE NUMBER

END

Client Notice: MC01-R1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	December, 1996

Description of Notice:	Notice of right to state hearing - change in law or policy. Benefit decrease due to a change in law or policy.
Assistance Categories:	All AGs except MAA, MAAP, MAB, MABP, MAD, MADP, MAM, MAMP, MAG, MAGP
Hearing Rights:	Yes
Program ID:	GMC020
Transaction ID:	MC020
Frequency:	Per request
Volume (est. monthly):	9
Form Number:	DHS 8523
Notes:	

WFAX 2149

IMPORTANT NOTICE

CUYAHOGA COUNTY DEPT OF HUMAN SERVICES
KAPPLE GREENS 2100
1221 ST CLAIR AVE
KLEAVLIN OH 441080000

As of 08/01/1996 you have used 04 months of your initial 36 months of Ohio Works First benefit eligibility. If you continue to be eligible, you have 32 months remaining. After you have used up your 36 months, you might be eligible for additional months. See your caseworker.

JOHN DOE
111 MAIN ST.

ANYWHERE, USA 11111-1111

Mailing Date: 06/02/1998
From: JANE DOE
Phone: (301) 777-9311 Ext: 1111

Worker ID: WFAX00
Case Number: 5000000000
AG Name: JOHN DOE

Dear JOHN DOE

Your DISABILITY ASSISTANCE (DA) benefits will be DECREASED from $0.00 to $0.00 effective 06/01/1998.

The following individuals are members of this assistance group:
JANE D (INELIGIBLE)

REASON:
The regulation supporting this action is contained in Section

GA A 1 R1

KEEP READING >>>

SEQ# 0009400 THIS SPACE FOR OFFICIAL USE ONLY
DHS 8523 (Rev. 12/96) 5000000000/GA A/01 NOTICE TYPE: MC01R1

AG Name:	Case Number:	Mailing Date:
JOHN DOE	5000000000	06/02/1998

YOUR RIGHT TO A STATE HEARING

This notice is to tell you about action we are taking on your case. If you do not understand this action, you should contact your caseworker. After talking to your caseworker, it is possible that we will change our decision or that you will agree with the action.

IF YOU BELIEVE THE NEW LAW OR POLICY HAS BEEN INCORRECTLY APPLIED TO YOUR CASE, YOU HAVE THE RIGHT TO A STATE HEARING. A state hearing lets you or your representative (lawyer, welfare rights worker, friend or relative) give your reasons against the action. We will also attend the hearing to present our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

If you want a hearing we must receive your hearing request within 90 days of the mailing date on this notice.

If we receive your request by 08/22/1996, the action will not be taken until the state hearing is decided. If you lose your hearing, you may have to pay back benefits that you were not eligible to receive.

If someone else makes a written hearing request for you, it must include a written statement, signed by you, telling us that person is your representative. Only you can make a request by telephone.

If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association, toll free a 1-(800)-589-5888, for the local number.

If you want a state hearing, check the appropriate box below, sign and date this form and send ALL PAGES to the Ohio Department of Human Services, State Hearings, 30 East Broad Street, 31st floor, Columbus, Ohio 43266-0423.

☐ I want a county conference and a state hearing.

☐ I want a state hearing only.

I want a hearing.

SIGNATURE	DATE	TELEPHONE NUMBER

END

Client Notice: MC01-R2

A client notice name is composed of th **Notice Type**, which is four characters and a n**Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	December, 1996

Description of Notice:	Increase in spenddown liability due to a change in law or policy.
Assistance Categories:	MAA, MAB, MAD AGs only
Hearing Rights:	Yes
Program ID:	GMC020
Transaction ID:	MC020
Frequency:	Per request
Volume (est. monthly):	0
Form Number:	DHS 8523
Notes:	

WFAX 2149

IMPORTANT NOTICE

CUYAHOGA COUNTY DEPT OF HUMAN SERVICES
KAPPLE GREENS 2100
1221 ST CLAIR AVE
KLEAVLIN OH 441080000

As of 06/01/1998 you have used 04 months of your initial 36 months of Ohio Works First benefit eligibility. If you continue to be eligible, you have 32 months remaining. After you have used up your 36 months, you might be eligible for additional months. See your caseworker.

JANE DOE
111 MAIN ST.

ANYWHERE, USA 11111-1111

Mailing Date: 06/02/1998
From : JANE DOE
Phone: (301) 777-9311 Ext: 1111

Worker ID : WFAX00
Case Number : 6000000000
AG Name : JANE DOE

Dear JANE DOE

Your monthly DISABILITY ASSISTANCE (DA) Spenddown liability will be INCREASED from $0.00 to $0.00 effective 06/01/1998.

The following individuals are members of this assistance group:
JANE D (INELIGIBLE)

REASON:
The regulation supporting this action is contained in Section

GA A 1 R2

KEEP READING >>>

SEQ# 0009500 THIS SPACE FOR OFFICIAL USE ONLY
DHS 8523 (Rev. 12/96) 6000000000/GA A/01 NOTICE TYPE: MC01R2

AG Name:	Case Number:	Mailing Date:
JANE DOE	6000000000	06/02/1998

YOUR RIGHT TO A STATE HEARING

This notice is to tell you about action we are taking on your case. If you do not understand this action, you should contact your caseworker. After talking to your caseworker, it is possible that we will change our decision or that you will agree with the action.

IF YOU BELIEVE THE NEW LAW OR POLICY HAS BEEN INCORRECTLY APPLIED TO YOUR CASE, YOU HAVE THE RIGHT TO A STATE HEARING. A state hearing lets you or your representative (lawyer, welfare rights worker, friend or relative) give your reasons against the action. We will also attend the hearing to present our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

If you want a hearing we must receive your hearing request within 90 days of the mailing date on this notice.

If we receive your request by 08/22/1996, the action will not be taken until the state hearing is decided. If you lose your hearing, you may have to pay back benefits that you were not eligible to receive.

If someone else makes a written hearing request for you, it must include a written statement, signed by you, telling us that person is your representative. Only you can make a request by telephone.

If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association, toll free a 1-(800)-589-5888, for the local number.

If you want a state hearing, check the appropriate box below, sign and date this form and send ALL PAGES to the Ohio Department of Human Services, State Hearings, 30 East Broad Street, 31st floor, Columbus, Ohio 43266-0423.

☐ I want a county conference and a state hearing.

☐ I want a state hearing only.

I want a hearing.

SIGNATURE	DATE	TELEPHONE NUMBER

END

Client Notice: MC01-R3

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	December, 1996

Description of Notice:	Increase in patient liability amount due to a change in law or policy.
Assistance Categories:	MAA, MAB, MAD AGs only
Hearing Rights:	Yes
Program ID:	GMC020
Transaction ID:	MC020
Frequency:	Per Request
Volume (est. monthly):	5
Form Number:	DHS 8523
Notes:	

WFAX 2149

IMPORTANT NOTICE

CUYAHOGA COUNTY DEPT OF HUMAN SERVICES
KAPPLE GREENS 2100
1221 ST CLAIR AVE
KLEAVLIN OH 441080000

As of 06/01/1998 you have used 04 months of your initial 36 months of Ohio Works First benefit eligibility. If you continue to be eligible, you have 32 months remaining. After you have used up your 36 months, you might be eligible for additional months. See your caseworker.

JANE DOE
111 MAIN ST.

ANYWHERE, USA 11111-1111

Mailing Date: 06/02/1998
From: JANE DOE
Phone: (301) 777-9311 Ext: 1111

Worker ID: WFAX00
Case Number: 7000000000
AG Name: JANE DOE

Dear JANE DOE

Your DISABILITY ASSISTANCE (DA) patient liability will be INCREASED from $0.00 to $0.00 effective 06/01/1998.

The following individuals are members of this assistance group:
JANE D (INELIGIBLE)

REASON:
The regulation supporting this action is contained in Section

GA A 1 R3

KEEP READING >>>

SEQ# 0009600 THIS SPACE FOR OFFICIAL USE ONLY
DHS 8523 (Rev. 12/96) 7000000000/GA A/01 NOTICE TYPE: MC01R3

AG Name:	Case Number:	Mailing Date:
JANE DOE	7000000000	06/02/1998

YOUR RIGHT TO A STATE HEARING

This notice is to tell you about action we are taking on your case. If you do not understand this action, you should contact your caseworker. After talking to your caseworker, it is possible that we will change our decision or that you will agree with the action.

IF YOU BELIEVE THE NEW LAW OR POLICY HAS BEEN INCORRECTLY APPLIED TO YOUR CASE, YOU HAVE THE RIGHT TO A STATE HEARING. A state hearing lets you or your representative (lawyer, welfare rights worker, friend or relative) give your reasons against the action. We will also attend the hearing to present our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

If you want a hearing we must receive your hearing request within 90 days of the mailing date on this notice.

If we receive your request by 08/22/1996, the action will not be taken until the state hearing is decided. If you lose your hearing, you may have to pay back benefits that you were not eligible to receive.

If someone else makes a written hearing request for you, it must include a written statement, signed by you, telling us that person is your representative. Only you can make a request by telephone.

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If you want a state hearing, check the appropriate box below, sign and date this form and send ALL PAGES to the Ohio Department of Human Services, State Hearings, 30 East Broad Street, 31st floor, Columbus, Ohio 43266-0423.

☐ I want a county conference and a state hearing.

☐ I want a state hearing only.

I want a hearing.

SIGNATURE	DATE	TELEPHONE NUMBER

END

Client Notice: MC01-T1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	December, 1996

Description of Notice:	Notice of benefit termination due to a change in law or policy.
Assistance Categories:	All AG's except MAM, MAG, MAMP, MAGP
Hearing Rights:	Yes
Program ID:	GMC020
Transaction ID:	MC020
Frequency:	Per request
Volume (est. monthly):	4
Form Number:	DHS 8523
Notes:	

WFAX 2149

IMPORTANT NOTICE

CUYAHOGA COUNTY DEPT OF HUMAN SERVICES
KAPPLE GREENS 2100
1221 ST CLAIR AVE
KLEAVLIN OH 441080000

As of 06/01/1998 you have used 04 months of your initial 36 months of Ohio Works First benefit eligibility. If you continue to be eligible, you have 32 months remaining. After you have used up your 36 months, you might be eligible for additional months. See your caseworker.

JANE DOE
111 MAIN ST.

ANYWHERE, USA 11111-1111

Mailing Date: 06/02/1998
From: JANE DOE
Phone: (301) 777-9311 Ext: 1111

Worker ID: WFAX00
Case Number: 8000000000
AG Name: JANE DOE

Dear JANET BROWN

Your DISABILITY ASSISTANCE (DA) benefits will be TERMINATED effective 06/01/1998.

The following individuals are members of this assistance group:
JANE D (INELIGIBLE)

REASON:
The regulation supporting this action is contained in Section

GA A 1 T1

KEEP READING >>>

SEQ# 0009700 THIS SPACE FOR OFFICIAL USE ONLY
DHS 8523 (Rev. 12/96) 8000000000/GA A/01 NOTICE TYPE: MC01T1

AG Name:	Case Number:	Mailing Date:
JANE DOE	8000000000	06/02/1998

YOUR RIGHT TO A STATE HEARING

This notice is to tell you about action we are taking on your case. If you do not understand this action, you should contact your caseworker. After talking to your caseworker, it is possible that we will change our decision or that you will agree with the action.

IF YOU BELIEVE THE NEW LAW OR POLICY HAS BEEN INCORRECTLY APPLIED TO YOUR CASE, YOU HAVE THE RIGHT TO A STATE HEARING. A state hearing lets you or your representative (lawyer, welfare rights worker, friend or relative) give your reasons against the action. We will also attend the hearing to present our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

If you want a hearing we must receive your hearing request within 90 days of the mailing date on this notice.

If we receive your request by 08/22/1996, the action will not be taken until the state hearing is decided. If you lose your hearing, you may have to pay back benefits that you were not eligible to receive.

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☐ I want a county conference and a state hearing.

☐ I want a state hearing only.

I want a hearing.

SIGNATURE	DATE	TELEPHONE NUMBER

END

Client Notice: MC01-T3

A client notice name is composed of th **Notice Type**, which is four characters and a n**Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	December, 1996

Description of Notice:	MEDICATION DEPENDENT MASS CHANGE - Termination of cash benefits.
Assistance Categories:	All MA except MA M, MAMP, MA G, MAGP
Hearing Rights:	Yes
Program ID:	GMC020
Transaction ID:	MC020
Frequency:	Per request
Volume (est. monthly):	
Form Number:	DHS 8523
Notes:	This notice overlays reason code 524 with reason code 530.

WFAX 2149

IMPORTANT NOTICE

CUYAHOGA COUNTY DEPT OF HUMAN SERVICES
KAPPLE GREENS 2100
1221 ST CLAIR AVE
KLEAVLIN OH 441080000

As of 06/01/1998 you have used 04 months of your initial 36 months of Ohio Works First benefit eligibility. If you continue to be eligible, you have 32 months remaining. After you have used up your 36 months, you might be eligible for additional months. See your caseworker.

JOHN DOE
111 MAIN ST.

ANYWHERE, USA 11111-1111

Mailing Date: 06/02/1998
From : JANE DOE
Phone: (301) 777-9311 Ext: 1111

Worker ID : WFAX00
Case Number : 9000000000
AG Name : JOHN DOE

Dear JOHN DOE

Your DISABILITY ASSISTANCE CASH ASSISTANCE BENEFITS will be TERMINATED effective 7/31/95. If you have no other income and you are now getting Disability Assistance Medical assistance, it will continue with no change. If it does change, you will get another notice. If you are now getting a JOBS participant expense allowance with your Disability Assistance check, it too will stop. However, if you are still required to participate after 8/1/95,your participant expense allowance will continue, but will be issued as a separate check.

The following individuals are members of this assistance group:
JANE D (INELIGIBLE)

REASON:
The regulation supporting this action is contained in Section

GA A 1 T3

KEEP READING >>>

SEQ# 0009800 THIS SPACE FOR OFFICIAL USE ONLY
DHS 8523 (Rev. 12/96) 9000000000/GA A/01 NOTICE TYPE: MC01T3

AG Name:	Case Number:	Mailing Date:
JOHN DOE	9000000000	06/02/1998

YOUR RIGHT TO A STATE HEARING

This notice is to tell you about action we are taking on your case. If you do not understand this action, you should contact your caseworker. After talking to your caseworker, it is possible that we will change our decision or that you will agree with the action.

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If you want a state hearing, check the appropriate box below, sign and date this form and send ALL PAGES to the Ohio Department of Human Services, State Hearings, 30 East Broad Street, 31st floor, Columbus, Ohio 43266-0423.

☐ I want a county conference and a state hearing.

☐ I want a state hearing only.

I want a hearing.

SIGNATURE	DATE	TELEPHONE NUMBER

END

Client Notice: PR01-A1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	April, 2000

Description of Notice:	Transitional ADC-related Medicaid Monthly Wages Report (Part 1)
Assistance Categories:	MA
Hearing Rights:	No
Program ID:	GPR006
Transaction ID:	PRUS
Frequency:	Monthly
Volume (est. monthly):	446
Form Number:	DHS 8598

Notes:

WHED 3026

0000001

IMPORTANT NOTICE

PICKAWAY COUNTY DEPT OF HUMAN SERVICES
110 ISLAND ROAD
P.O. BOX 439
CIRCLEVILLE OH 431130000

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 03/08/2000
From: HAZEL E DUMM
Phone: (740) 474-7588 Ext:

Worker ID: WHED65
Case Number: 9999999999
AG Name: JANE DOE

Dear JANE DOE

THIS REPORT IS DUE BY 03/20/2000

To continue to receive Transitional Medicaid, you must complete this report. This report is due by the date indicated above. You must tell us about your household's earnings during the last three months.

Please answer the following questions, sign the report, attach pay stubs or other proof of earnings, if needed, and make sure these are received by your county department of human services no later than the date indicated above.

If this report is not received by the date indicated above, your Medicaid coverage may be delayed or cancelled.

Your answers on this form will be used to see if your household's Transitional Medicaid continues.

KEEP READING >>>

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1. WAGES

In figuring your earnings, use your household's total monthly wages before deductions for taxes, retirement, etc. This is called gross earnings. Do NOT add in money your household receives from other types of income, like Social Security, SSI, or Worker's Comp.

NOTE: WHILE EARNED INCOME IS THE ONLY INCOME WHICH IMPACTS YOUR TRANSITIONAL MEDICAID ELIGIBILITY, YOU CONTINUE TO BE RESPONSIBLE FOR TIMELY REPORTING ALL CHANGES IN YOUR CIRCUMSTANCES TO YOUR CASEWORKER(SUCH AS AN INCREASE IN UNEARNED INCOME OR THE ADDITION OF A NEW FAMILY MEMBER.)

You need to report earned income for each of the last three months; include all wages received between the first day and the last day of each month. **ATTACH PAY STUBS** or other proof.

	Last Month	Month Before	Month Before That
Household's Gross Earnings:	$ _____	$ _____	$ _____

Has anyone in the household lost a job during this (3) three month period? YES_____ NO _____

IF YES: WHO_____ WHEN_____
First Name Last Name

WHY _____

Name and address of former employer _____
_____
_____

RIGHTS, RESPONSIBILITIES, AND SIGNATURE:

I know that the information I give in this report will be used to decide whether my Transitional Medicaid will continue or be stopped. I know that if it is to be stopped you will send me a notice before stopping it. The notice will tell me how to request a state hearing if I do not agree.

I understand there are penalties for withholding or giving false information. I also understand I would owe for any medical benefits I received because I did not fully report changes in my household. If asked, I agree to provide proof of any changes I report.

I have read and understood this explanation of my rights and responsibilities. My answers on this report are correct and complete to the best of my knowledge.

SIGNATURE	DATE	TELEPHONE NUMBER

END

Client Notice: PR01-A2

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	April, 2000

Description of Notice:	Transitional ADC-related Medicaid Monthly Child Care Report (Part 2)
Assistance Categories:	MA
Hearing Rights:	No
Program ID:	GPR006
Transaction ID:	PRUS
Frequency:	Monthly
Volume (est. monthly):	200
Form Number:	DHS 8598

Notes:

WJML 2002

0000003

IMPORTANT NOTICE

LUCAS COUNTY DEPT OF HUMAN SERVICES
3210 MONROE ST.
P.O. BOX 10007
TOLEDO OH 436990007

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 03/08/2000
From: J LONG
Phone: (419) 213-8567 Ext:

Worker ID: WJML48
Case Number: 9999999999
AG Name: JANE DOE

Dear JANE DOE

THIS REPORT IS DUE BY 03/20/2000

To continue to receive Transitional Medicaid, you must complete this report. This report is due by the date indicated above. You must tell us about any changes in your household during the last three months.

Please answer the following questions, sign the report, attach pay stubs or other proof of earnings, if needed, and make sure these are received by your county department of human services no later than the date indicated above.

If this report is not received by the date indicated above, your Medicaid coverage may be delayed or cancelled.

Your answers on this form will be used to see if your household's Transitional Medicaid continues.

KEEP READING >>>

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2. CHILD CARE

You need to tell us how much your household is spending on child care while the caretaker is working. Please do not include money spent for child care for recreational time away from home (movies, bowling, etc.). If someone else is paying your child care, do NOT include what they spend.

	Last Month	Month Before	Month Before That
Child Care Costs:	$ _____	$ _____	$ _____

RIGHTS, RESPONSIBILITIES, AND SIGNATURE:

I know that the information I give in this report will be used to decide whether my Transitional Medicaid will continue or be stopped. I know that if it is to be stopped you will send me a notice before stopping it. The notice will tell me how to request a state hearing if I do not agree.

I understand there are penalties for withholding or giving false information. I also understand I would owe for any medical benefits I received because I did not fully report changes in my household. If asked, I agree to provide proof of any changes I report.

I have read and understood this explanation of my rights and responsibilities. My answers on this report are correct and complete to the best of my knowledge.

SIGNATURE	DATE	TELEPHONE NUMBER

END

Client Notice: PR01-A3

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	April, 2000

Description of Notice:	Transitional ADC-related Medicaid Monthly Changes In Household Members Report (Part 3)
Assistance Categories:	MA
Hearing Rights:	No
Program ID:	GPR006
Transaction ID:	PRUS
Frequency:	Monthly
Volume (est. monthly):	40
Form Number:	DHS 8598
Notes:	

WJML 2002

0000006

IMPORTANT NOTICE

LUCAS COUNTY DEPT OF HUMAN SERVICES
3210 MONROE ST.
P.O. BOX 10007
TOLEDO OH 436990007

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 03/08/2000
From: J LONG
Phone: (419) 213-8567 Ext:

Worker ID: WJML48
Case Number: 9999999999
AG Name: JANE DOE

Dear JANE DOE

THIS REPORT IS DUE BY 03/20/2000

To continue to receive Transitional Medicaid, you must complete this report. This report is due by the date indicated above. You must tell us about any changes in your household during the last three months.

Please answer the following questions, sign the report, attach pay stubs or other proof of earnings, if needed, and make sure these are received by your county department of human services no later than the date indicated above.

If this report is not received by the date indicated above, your Medicaid coverage may be delayed or cancelled.

Your answers on this form will be used to see if your household's Transitional Medicaid continues.

KEEP READING >>>

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3. CHANGES IN HOUSEHOLD MEMBERS

In the last three months, has anyone moved in or out of your home? YES _____ NO _____

IF YES: NAME _____ AGE _____ DATE OF CHANGE _____
First Name Last Name

REASON FOR CHANGE _____
_____

RIGHTS, RESPONSIBILITIES, AND SIGNATURE:

I know that the information I give in this report will be used to decide whether my Transitional Medicaid will continue or be stopped. I know that if it is to be stopped you will send me a notice before stopping it. The notice will tell me how to request a state hearing if I do not agree.

I understand there are penalties for withholding or giving false information. I also understand I would owe for any medical benefits I received because I did not fully report changes in my household. If asked, I agree to provide proof of any changes I report.

I have read and understood this explanation of my rights and responsibilities. My answers on this report are correct and complete to the best of my knowledge.

SIGNATURE	DATE	TELEPHONE NUMBER

END

Client Notice: PR01-A4

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	April, 2000

Description of Notice:	Transitional ADC-related Medicaid Monthly Change Of Address Report (Part 4)
Assistance Categories:	MA
Hearing Rights:	No
Program ID:	GPR006
Transaction ID:	PRUS
Frequency:	Monthly
Volume (est. monthly):	40
Form Number:	DHS 8598

Notes:

WJML 2002

0000007

IMPORTANT NOTICE

LUCAS COUNTY DEPT OF HUMAN SERVICES
3210 MONROE ST.
P.O. BOX 10007
TOLEDO OH 436990007

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 03/08/2000
From: J LONG
Phone: (419) 213-8567 Ext:

Worker ID: WJML48
Case Number: 9999999999
AG Name: JANE DOE

Dear JANE DOE

THIS REPORT IS DUE BY 03/20/2000

To continue to receive Transitional Medicaid, you must complete this report. This report is due by the date indicated above. You must tell us about any changes in your household during the last three months.

Please answer the following questions, sign the report, attach pay stubs or other proof of earnings, if needed, and make sure these are received by your county department of human services no later than the date indicated above.

If this report is not received by the date indicated above, your Medicaid coverage may be delayed or cancelled.

Your answers on this form will be used to see if your household's Transitional Medicaid continues.

KEEP READING >>>

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4. CHANGE OF ADDRESS

Complete this section if you have moved.

Street _____			Telephone Number _____
City _____		State _____	Zip Code_____

RIGHTS, RESPONSIBILITIES, AND SIGNATURE:

I know that the information I give in this report will be used to decide whether my Transitional Medicaid will continue or be stopped. I know that if it is to be stopped you will send me a notice before stopping it. The notice will tell me how to request a state hearing if I do not agree.

I understand there are penalties for withholding or giving false information. I also understand I would owe for any medical benefits I received because I did not fully report changes in my household. If asked, I agree to provide proof of any changes I report.

I have read and understood this explanation of my rights and responsibilities. My answers on this report are correct and complete to the best of my knowledge.

SIGNATURE	DATE	TELEPHONE NUMBER

END

Client Notice: PR01-A5

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	April, 2000

Description of Notice:	Transitional ADC-related Medicaid Changes In Next Month Report (Part 5)
Assistance Categories:	MA
Hearing Rights:	No
Program ID:	GPR006
Transaction ID:	PRUS
Frequency:	Monthly
Volume (est. monthly):	40
Form Number:	DHS 8598
Notes:	

WJML 2002

0000005

IMPORTANT NOTICE

LUCAS COUNTY DEPT OF HUMAN SERVICES
3210 MONROE ST.
P.O. BOX 10007
TOLEDO OH 436990007

JANE DOE
111 MAIN ST

ANYWHERE OH 99999-9999

Mailing Date: 03/08/2000
From: J LONG
Phone: (419) 213-8567 Ext:

Worker ID: WJML48
Case Number: 9999999999
AG Name: JANE DOE

Dear JANE DOE

THIS REPORT IS DUE BY 03/20/2000

To continue to receive Transitional Medicaid, you must complete this report. This report is due by the date indicated above. You must tell us about any upcoming changes.

Please answer the following questions, sign the report, attach pay stubs or other proof of earnings, if needed, and make sure these are received by your county department of human services no later than the date indicated above.

If this report is not received by the date indicated above, your Medicaid coverage may be delayed or cancelled.

Your answers on this form will be used to see if your household's Transitional Medicaid continues.

KEEP READING >>>

* *

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* *

5. CHANGES NEXT MONTH

Do you expect any changes in these areas next month? YES _____ NO _____

If yes, explain in the space below.

_____

_____

_____

RIGHTS, RESPONSIBILITIES, AND SIGNATURE:

I know that the information I give in this report will be used to decide whether my Transitional Medicaid will continue or be stopped. I know that if it is to be stopped you will send me a notice before stopping it. The notice will tell me how to request a state hearing if I do not agree.

I understand there are penalties for withholding or giving false information. I also understand I would owe for any medical benefits I received because I did not fully report changes in my household. If asked, I agree to provide proof of any changes I report.

I have read and understood this explanation of my rights and responsibilities. My answers on this report are correct and complete to the best of my knowledge.

SIGNATURE	DATE	TELEPHONE NUMBER

END

Client Notice: PR01-AA

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	April, 2000

Description of Notice:	Transitional ADC-related Medicaid Monthly Report (All); Includes fill-in parts 1 thru 5.
Assistance Categories:	MA
Hearing Rights:	No
Program ID:	GPR001
Transaction ID:	PR001
Frequency:	Monthly
Volume (est. monthly):	7000
Form Number:	DHS 8598
Notes:	

WFAA 3014

0000002

IMPORTANT NOTICE

DEFIANCE COUNTY DEPT OF HUMAN SERVICES
06879 EVANSPORT RD.
P.O. BOX 639
DEFIANCE OH 435120000

JANE DOE
111 MAIN ST
ANYWHERE OH 99999-9999

Mailing Date: 03/08/2000
From: FARAH A ALI
Phone: (614) 719-8677 Ext:

Worker ID: WFAA25
Case Number: 9999999999
AG Name: JANE DOE

Dear JANE DOE

THIS REPORT IS DUE BY 04/05/2000

To continue to receive Transitional Medicaid, you must complete this report. This report is due by the date indicated above.You must tell us about your household's earnings during the last three months.

Please answer the following questions, sign the report, attach pay stubs or other proof of earnings and make sure these are received by your county department of human services no later than the 5th of the month.

If this report is not received by the date indicated above, your Medicaid coverage may be delayed or cancelled.

Your answers on this form will be used to see if your household's Transitional Medicaid continues.

KEEP READING >>>

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1. WAGES

In figuring your earnings, use your household's total monthly wages before deductions for taxes, retirement, etc. This is called gross earnings. Do NOT add in money your household receives from other types of income, like Social Security, SSI or Worker's Comp.

NOTE: WHILE EARNED INCOME IS THE ONLY INCOME WHICH IMPACTS YOUR TRANSITIONAL ADC-RELATED MEDICAID ELIGIBILITY, YOU CONTINUE TO BE RESPONSIBLE FOR TIMELY REPORTING ALL CHANGES IN YOUR CIRCUMSTANCES TO YOUR CASEWORKER (SUCH AS AN INCREASE IN UNEARNED INCOME OR THE ADDITION OF A NEW FAMILY MEMBER).

You need to report earned income for each of the last three months; include all wages received between the first day and the last day of each month. **ATTACH PAY STUBS** or other proof.

	Last Month	Month Before	Month Before That
Household's Gross Earnings:	$ _____	$ _____	$ _____

Has anyone in the household lost a job during this (3) three month period? YES _____ NO _____

IF YES: WHO _____ WHEN _____
First Name Last Name

WHY _____

Name and address of former employer _____
_____
_____

2. CHILD CARE

You need to tell us how much your household is spending on child care while the caretaker is working. Please do not include money spent for child care for recreational time away from home (movies, bowling, etc.). If someone else is paying your child care, do NOT include what they spend.

	Last Month	Month Before	Month Before That
Child Care Costs:	$ _____	$ _____	$ _____

3. CHANGES IN HOUSEHOLD MEMBERS

In the last three months, has anyone moved in or out of your home? YES _____ NO _____

IF YES: NAME _____ AGE _____ DATE OF CHANGE _____
First Name Last Name

REASON FOR CHANGE _____
_____

KEEP READING >>>

4. CHANGE OF ADDRESS

Complete this section if you have moved.

Street	_____		Telephone Number _____
City	_____	State _____	Zip Code_____

5. CHANGES NEXT MONTH

Do you expect any changes in these areas next month? YES _____ NO _____

If yes, explain in the space below.

_____

_____

_____

RIGHTS, RESPONSIBILITIES, AND SIGNATURE:

I know that the information I give in this report will be used to decide whether my Transitional Medicaid will continue or be stopped. I know that if it is to be stopped you will send me a notice before stopping it. The notice will tell me how to request a state hearing if I do not agree.

I understand there are penalties for withholding or giving false information. I also understand I would owe for any medical benefits I received because I did not fully report changes in my household. If asked, I agree to provide proof of any changes I report.

I have read and understood this explanation of my rights and responsibilities. My answers on this report are correct and complete to the best of my knowledge.

SIGNATURE	DATE	TELEPHONE NUMBER

END

Client Notice: WP02-W2

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	December, 1997

Description of Notice:	Individual work schedule(worksite copy)
Assistance Categories:	ADC, FS, GA
Hearing Rights:	No
Program ID:	GCN010
Transaction ID:	
Frequency:	Daily
Volume (est. monthly):	32000
Form Number:	DHS 8527
Notes:	The General Assistance program was terminated 7/31/95

0000040 WDME

DELAWARE COUNTY DEPT OF HUMAN SERVICES
149 N. SANDUSKY ST.

DELAWARE OH 430150000

IMPORTANT NOTICE

ABC CO. DEPARTMENT OF
HUMAN SERVICES
111 MAIN ST.
ANYWHERE, USA 11111-1111

Mailing Date: 05/13/1998
From: DONNA M ECKMAN
Phone: (614) 368-1990 Ext:

Worker ID: WDME21
Case Number: 1111111111
AG Name: JANE DOE

Dear ABC CO. DEPARTMENT OF

This is the schedule for JANE DOE (Recipient Number: 111111111111), who has been assigned to complete 30.0 hours at:

ABC CO. DEPARTMENT OF
HUMAN SERVICES
111 MAIN ST..
ANYWHERE USA 11111-1111

The schedule on the reverse side of this notice should be completed by the site supervisor or designee to indicate the actual number of hours completed each day. Please sign and date the schedule and return it to the DELAWARE County Department of Human Services at the above address. Please note the special instructions listed at the bottom of this notice.

Thank you for your cooperation. If you have any questions concerning this notice, please contact this JOBS worker:

DONNA M ECKMAN
(614) 368-1990 extension

Please note these special instructions:

PLEASE TRACK THE HOURS THAT YOU CONDUCT YOUR JOB SEARCH. RETURN THIS SCHEDULE TO DONNA BY THE 7TH OF JUNE. GOOD LUCK]

SIGNATURE: _____ TITLE: _____ DATE: _____

REMARKS: _____

KEEP READING >>>

SEQ# 0026038 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000040
ODS 8528 (Rev. 12/97) 1111111111/FS /01 NOTICE TYPE: WP02W2

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
					1 Start End Start End Sched Hrs Compl Hrs	2 Start End Start End Sched Hrs Compl Hrs
3 Start End Start End Sched Hrs Compl Hrs	4 Start End Start End Sched Hrs Compl Hrs	5 Start End Start End Sched Hrs Compl Hrs	6 Start End Start End Sched Hrs Compl Hrs	7 Start End Start End Sched Hrs Compl Hrs	8 Start End Start End Sched Hrs Compl Hrs	9 Start End Start End Sched Hrs Compl Hrs
10 Start End Start End Sched Hrs Compl Hrs	11 Start End Start End Sched Hrs Compl Hrs	12 Start End Start End Sched Hrs Compl Hrs	13 Start End Start End Sched Hrs Compl Hrs	14 Start End Start End Sched Hrs Compl Hrs	15 Start End Start End Sched Hrs Compl Hrs	16 Start End Start End Sched Hrs Compl Hrs
17 Start End Start End Sched Hrs Compl Hrs	18 Start End Start End Sched Hrs Compl Hrs	19 Start End Start End Sched Hrs Compl Hrs	20 Start End Start End Sched Hrs Compl Hrs	21 Start End Start End Sched Hrs Compl Hrs	22 Start End Start End Sched Hrs Compl Hrs	23 Start End Start End Sched Hrs Compl Hrs
24 Start End Start End Sched Hrs Compl Hrs	25 Start End Start End Sched Hrs Compl Hrs	26 Start End Start End Sched Hrs Compl Hrs	27 Start End Start End Sched Hrs Compl Hrs	28 Start End Start End Sched Hrs Compl Hrs	29 Start End Start End Sched Hrs Compl Hrs	30 Start End Start End Sched Hrs Compl Hrs
31 Start End Start End Sched Hrs Compl Hrs						

MAY , 1998

JOBS PARTICIPATION SCHEDULE FOR

JANE DOE

AT

ABC CO. DEPARTMENT OF

PRINT SEQ. 0000040

Client Notice: WP03-W3

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	December, 1997

Description of Notice:	Work schedule(participant copy)
Assistance Categories:	ADC, FS, GA
Hearing Rights:	No
Program ID:	GRP035
Transaction ID:	
Frequency:	Daily
Volume (est. monthly):	32000
Form Number:	DHS 8528

Notes:

0000036 WSAR

LICKING COUNTY DEPT OF HUMAN SERVICES
P.O. BOX 5030

NEWARK OH 430585030

IMPORTANT NOTICE

JANE DOE
111 MAIN ST.

ANYWHERE, USA 11111-1111

Mailing Date: 05/13/1998
From: SUE A RUPPERSBURG
Phone: (614) 349-6305 Ext:

Worker ID: WSAR45
Case Number: 1111111111
AG Name: JANE DOE

Recipient Number: 111111111111

Dear JANE DOE

Your JOBS Program schedule for MAY, 1998, is on the reverse side of this notice. You are assigned to participate for 129.0 hours at:

L C JOINT VOCATIONAL SCHOOL
150 PRICE ROAD

NEWARK OH 430550000.

If you have any questions concerning this notice, please contact your JOBS worker:

SUE A RUPPERSBURG
(614) 349-6305 extension

Failure to complete the hours assigned could result in the reduction or termination of your benefits.

Please note these special instructions:
PLEASE COMPLETE AS ASSIGNED. THANKYOU AND GOOD LUCK]

KEEP READING >>>

SEQ# 0026545 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000036
ODS 8528 (Rev. 12/97) 1111111111/ADCR/01 NOTICE TYPE: WP03W3

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
					1 Start End Start End Sched Hrs Compl Hrs	2 Start End Start End Sched Hrs Compl Hrs
3 Start End Start End Sched Hrs Compl Hrs	4 Start End Start End Sched Hrs Compl Hrs	5 Start End Start End Sched Hrs Compl Hrs	6 Start End Start End Sched Hrs Compl Hrs	7 Start End Start End Sched Hrs Compl Hrs	8 Start End Start End Sched Hrs Compl Hrs	9 Start End Start End Sched Hrs Compl Hrs
10 Start End Start End Sched Hrs Compl Hrs	11 Start End Start End Sched Hrs Compl Hrs	12 Start End Start End Sched Hrs Compl Hrs	13 Start End Start End Sched Hrs Compl Hrs	14 Start End Start End Sched Hrs Compl Hrs	15 Start End Start End Sched Hrs Compl Hrs	16 Start End Start End Sched Hrs Compl Hrs
17 Start End Start End Sched Hrs Compl Hrs	18 Start End Start End Sched Hrs Compl Hrs	19 Start End Start End Sched Hrs Compl Hrs	20 Start End Start End Sched Hrs Compl Hrs	21 Start End Start End Sched Hrs Compl Hrs	22 Start End Start End Sched Hrs Compl Hrs	23 Start End Start End Sched Hrs Compl Hrs
24 Start End Start End Sched Hrs Compl Hrs	25 Start End Start End Sched Hrs Compl Hrs	26 Start End Start End Sched Hrs Compl Hrs	27 Start End Start End Sched Hrs Compl Hrs	28 Start End Start End Sched Hrs Compl Hrs	29 Start End Start End Sched Hrs Compl Hrs	30 Start End Start End Sched Hrs Compl Hrs
31 Start End Start End Sched Hrs Compl Hrs						

MAY , 1998

JOBS PARTICIPATION SCHEDULE FOR

JANE DOE

AT

L C JOINT VOCATIONAL SCHOOL

PRINT SEQ. 0000036

Client Notice: WP06-A1

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	December, 1997

Description of Notice:	LEAP Notice - school report of unexcused & excused absences
Assistance Categories:	ADC
Hearing Rights:	No
Program ID:	GWP046
Transaction ID:	WPLT
Frequency:	Daily
Volume (est. monthly):	400
Form Number:	DHS 8567
Notes:	

0000077 WMHH 0084

HAMILTON COUNTY DEPT OF HUMAN SERVICES
222 E. CENTRAL PARKWAY

CINCINNATI OH 452020000

IMPORTANT NOTICE

As of 05/12/1998 you have used 07 months of your initial 36 months of Ohio Works First benefit eligibility. If you continue to be eligible, you have 29 months remaining. After you have used up your 36 months, you might be eligible for additional months. See your caseworker.

JANE DOE
111 MAIN ST.

ANYWHERE, USA 11111-1111

Mailing Date: 05/13/1998
From: MICHELE J HARRIS
Phone: (513) 946-1627 Ext:

Worker ID: WMHH31
Case Number: 1111111111
AG Name: JANE DOE

Dear JANE DOE

The school (SCHWAB MIDDLE SCHOOL) reported that JANE DOE had 5.0 total absences (excused and unexcused), which is more than the number allowed to receive the attendance bonus. The dates of the absences were:

03/02/1998 F
03/03/1998 F
03/04/1998 F
03/05/1998 F
03/06/1998 F

(NOTE: F = full day absence. H = half day absence.)

If you had more than the allowed number of excused absences to receive the attendance bonus and doctors' excuses were not provided for those absences over the allowed number, then your family will not be eligible for the $62.00 attendance bonus.

Read all pages of this form. If you want to claim "good cause", fill out the information requested. You and the assistance group payee need to sign it. Then return the form within seven days of the mailing date with any proof requested to us at the above address.

We must receive this form by 05/20/1998. If we do not receive this form by this date, we will assume that you did not have good cause for not being in school. If you did not have good cause, the penalty will be applied. We will send your family another notice before any penalty is taken.

Any action we take based on your attendance will affect your family's JUNE, 1998, ADCR check.

KEEP READING >>>

SEQ# 0025410 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000077
ODS 8567 (Rev. 12/97) 1111111111/ADCR/01 NOTICE TYPE: WP06A1

READ PAGE ONE OF THIS FORM FIRST. THEN READ THIS PAGE AND THE NEXT PAGE. IF YOU WANT TO CLAIM GOOD CAUSE, FILL OUT PAGE TWO AND THREE. RETURN THIS FORM TO US BY 05/20/1998.

Check any of these boxes that apply to you. Write the date of the absence beside the reason that applies. There is a space at the bottom for you to write more information.

☐ _____ Date(s) I am attending a different school. (Provide Proof.)

☐ _____ Date(s) I have already graduated from high school or have received a **GED** certificate. (Provide proof.)

☐ _____ Date(s) I did not have transportation to school or child care. (Explain below.)

☐ _____ Date(s) I was not able to get child care for my child. (Explain below.)

☐ _____ Date(s) I was ill or injured and was unable to attend school. (Explain below. If you went to a doctor, provide proof.)

☐ _____ Date(s) My child was ill or injured and I needed to stay home and care for my child. (Explain below. If you went to a doctor, provide proof.)

☐ _____ Date(s) _____ (name of relative and relationship) was ill or injured and I needed to stay home to care for this person.

☐ _____ Date(s) A member of my family died. (Tell us who and when below.)

KEEP READING >>>

☐ _____ Date(s) I was not in school because either I or my child had a medical appointment. (Explain below and provide proof.)

☐ _____ Date(s) I was not in school because I had an appointment at the county department of human services (Explain below.)

☐ _____ Date(s) I was not in school because either I or my child had to appear in court during school hours. (Explain below.)

☐ _____ Date(s) I was not in school for other reasons. (Explain below.)

☐ _____ Date(s) I was in class on the day(s) that the school reported I was absent. (Explain below.)

GIVE INFORMATION HERE TO HELP IN DECIDING IF YOU HAD 'GOOD CAUSE' FOR NOT GOING TO SCHOOL.

Signature of Teen		
SIGNATURE	DATE	TELEPHONE NUMBER

Assistance Group Payee's Signature		
SIGNATURE	DATE	TELEPHONE NUMBER

IF YOU NEED HELP SO THAT YOU CAN ATTEND SCHOOL (CHILD CARE, TRANSPORTATION, PARENTING CLASSES), CONTACT THE WORKER ON THE FIRST PAGE.

END

Client Notice: WP06-A2

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	December, 1997

Description of Notice:	LEAP Notice - absences from GED program; Initial notice
Assistance Categories:	ADC
Hearing Rights:	No
Program ID:	GWP046
Transaction ID:	WPLT
Frequency:	Daily
Volume (est. monthly):	80
Form Number:	DHS 8567
Notes:	

0000026 WKDB 2417

ASHTABULA COUNTY DEPT OF HUMAN SERVICES
2924 DONAHOE DR.

ASHTABULA OH 440040000

IMPORTANT NOTICE

As of 05/12/1998 you have used 08 months of your initial 36 months of Ohio Works First benefit eligibility. If you continue to be eligible, you have 28 months remaining. After you have used up your 36 months, you might be eligible for additional months. See your caseworker.

JANE DOE
111 MAIN ST.

ANYWHERE, USA 11111-1111

Mailing Date: 05/13/1998
From: KRISTA BROOKS
Phone: (440) 998-1110 Ext:

Worker ID: WKDB04
Case Number: 1111111111
AG Name: JANE DOE

Dear JANE DOE

The school (ABE-ASHTABULA CO. J.V. SCHOOL) reported that JANE DOE was absent on the following dates:

02/02/1998 F	02/10/1998 F	02/19/1998 F
02/03/1998 F	02/11/1998 F	02/23/1998 F
02/04/1998 F	02/12/1998 F	02/24/1998 F
02/05/1998 F	02/17/1998 F	02/25/1998 F
02/09/1998 F	02/18/1998 F	02/26/1998 F

(NOTE: F = full day absence. H = half day absence.)

Since you attend a **GED** program which does not determine whether the absences are excused or unexcused, you need to complete the following pages of this form and send them in so we can determine if the absences are excused or unexcused. Once we make this determination, we will send your family another notice before any penalty is taken.

Read all pages of this form. If you want to claim "good cause", fill out the information requested. You and the assistance group payee need to sign it. Then return the form within seven days of the mailing date with any proof requested to us at the above address.

We must receive this form by 05/20/1998. If we do not receive this form by this date, we will assume that you did not have good cause for not being in school. If you did not have good cause, the penalty will be applied. We will send your family another notice before any penalty is taken.

Any action we take based on your attendance will affect your family's MAY, 1998, ADCR check.

KEEP READING >>>

READ PAGE ONE OF THIS FORM FIRST. THEN READ THIS PAGE AND THE NEXT PAGE. IF YOU WANT TO CLAIM GOOD CAUSE, FILL OUT PAGE TWO AND THREE. RETURN THIS FORM TO US BY 05/20/1998.

Check any of these boxes that apply to you. Write the date of the absence beside the reason that applies. There is a space at the bottom for you to write more information.

☐ _____ Date(s) I am attending a different school. (Provide Proof.)

☐ _____ Date(s) I have already graduated from high school or have received a **GED** certificate. (Provide proof.)

☐ _____ Date(s) I did not have transportation to school or child care. (Explain below.)

☐ _____ Date(s) I was not able to get child care for my child. (Explain below.)

☐ _____ Date(s) I was ill or injured and was unable to attend school. (Explain below. If you went to a doctor, provide proof.)

☐ _____ Date(s) My child was ill or injured and I needed to stay home and care for my child. (Explain below. If you went to a doctor, provide proof.)

☐ _____ Date(s) _____ (name of relative and relationship) was ill or injured and I needed to stay home to care for this person.

☐ _____ Date(s) A member of my family died. (Tell us who and when below.)

☐ _____ Date(s) I was not in school because either I or my child had a medical appointment. (Explain below and provide proof.)

☐ _____ Date(s) I was not in school because I had an appointment at the county department of human services (Explain below.)

☐ _____ Date(s) I was not in school because either I or my child had to appear in court during school hours. (Explain below.)

☐ _____ Date(s) I was not in school for other reasons. (Explain below.)

☐ _____ Date(s) I was in class on the day(s) that the school reported I was absent. (Explain below.)

GIVE INFORMATION HERE TO HELP IN DECIDING IF YOU HAD 'GOOD CAUSE' FOR NOT GOING TO SCHOOL.

Signature of Teen		
SIGNATURE	DATE	TELEPHONE NUMBER

Assistance Group Payee's Signature		
SIGNATURE	DATE	TELEPHONE NUMBER

IF YOU NEED HELP SO THAT YOU CAN ATTEND SCHOOL (CHILD CARE, TRANSPORTATION, PARENTING CLASSES), CONTACT THE WORKER ON THE FIRST PAGE.

END

Client Notice: WP06-A3

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	December, 1997

Description of Notice:	LEAP Notice - excessive unexcused absences
Assistance Categories:	ADC
Hearing Rights:	No
Program ID:	GWP046
Transaction ID:	WPLT
Frequency:	Daily
Volume (est. monthly):	1800
Form Number:	DHS 8567

Notes:

0000075 WIJB 0084

HAMILTON COUNTY DEPT OF HUMAN SERVICES
222 E. CENTRAL PARKWAY

CINCINNATI OH 452020000

IMPORTANT NOTICE

As of 05/12/1998 you have used 08 months of your initial 36 months of Ohio Works First benefit eligibility. If you continue to be eligible, you have 28 months remaining. After you have used up your 36 months, you might be eligible for additional months. See your caseworker.

JANE DOE
111 MAIN ST.

ANYWHERE, USA 11111-1111

Mailing Date: 05/13/1998
From: IVIE J BELL
Phone: (513) 946-1628 Ext:

Worker ID: WIJB31
Case Number: 1111111111
AG Name: JANE DOE

Dear JANE DOE

The school (GED-HARRIET BEECHER STOWE HOUS) reported that JANE DOE had more unexcused absences than the attendance requirements permit. The dates of the absences were:

04/01/1998 F	04/09/1998 F	04/23/1998 F	04/30/1998 F
04/03/1998 F	04/10/1998 F	04/24/1998 F	
04/06/1998 F	04/14/1998 F	04/27/1998 F	
04/07/1998 F	04/20/1998 F	04/28/1998 F	
04/08/1998 F	04/22/1998 F	04/29/1998 F	

(NOTE: F = full day absence. H = half day absence.)

If you had more than the allowed number of unexcused absences and you did not have "good cause", then your family's regular **ADCR** check will be reduced by $62.00. In addition, you will not be eligible for the $62.00 attendance bonus.

Read all pages of this form. If you want to claim "good cause", fill out the information requested. You and the assistance group payee need to sign it. Then return the form within seven days of the mailing date with any proof requested to us at the above address.

We must receive this form by 05/20/1998. If we do not receive this form by this date, we will assume that you did not have good cause for not being in school. If you did not have good cause, the penalty will be applied. We will send your family another notice before any penalty is taken.

Any action we take based on your attendance will affect your family's JULY, 1998, ADCR check.

KEEP READING >>>

SEQ# 0025426 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000075
ODS 8567 (Rev. 12/97) 1111111111/ADCR/03 NOTICE TYPE: WP06A3

READ PAGE ONE OF THIS FORM FIRST. THEN READ THIS PAGE AND THE NEXT PAGE. IF YOU WANT TO CLAIM GOOD CAUSE, FILL OUT PAGE TWO AND THREE. RETURN THIS FORM TO US BY 05/20/1998.

Check any of these boxes that apply to you. Write the date of the absence beside the reason that applies. There is a space at the bottom for you to write more information.

☐ _____ Date(s) I am attending a different school. (Provide Proof.)

☐ _____ Date(s) I have already graduated from high school or have received a **GED** certificate. (Provide proof.)

☐ _____ Date(s) I did not have transportation to school or child care. (Explain below.)

☐ _____ Date(s) I was not able to get child care for my child. (Explain below.)

☐ _____ Date(s) I was ill or injured and was unable to attend school. (Explain below. If you went to a doctor, provide proof.)

☐ _____ Date(s) My child was ill or injured and I needed to stay home and care for my child. (Explain below. If you went to a doctor, provide prooj.)

☐ _____ Date(s) _____ (name of relative and relationship) was ill was ill or injured and I needed to stay home to care for this person.

☐ _____ Date(s) A member of my family died. (Tell us who and when below.)

☐ _____ Date(s) I was not in school because either I or my child had a medical appointment. (Explain below and provide proof.)

☐ _____ Date(s) I was not in school because I had an appointment at the county department of Human Services. (Explain below.)

☐ _____ Date(s) I was not in school because either I or my child had to appear in court during during school hours. (Explain below.)

☐ _____ Date(s) I was not in school for other reasons. (Explain below.)

☐ _____ Date(s) I was in class on the day(s) that the school reported I was absent. (Explain below.)

GIVE INFORMATION HERE TO HELP IN DECIDING IF YOU HAD 'GOOD CAUSE' FOR NOT GOING TO SCHOOL.

Signature of Teen		
SIGNATURE	DATE	TELEPHONE NUMBER

Assistance Group Payee's Signature		
SIGNATURE	DATE	TELEPHONE NUMBER

IF YOU NEED HELP SO THAT YOU CAN ATTEND SCHOOL (CHILD CARE, TRANSPORTATION, PARENTING CLASSES), CONTACT THE WORKER ON THE FIRST PAGE.

END

SEQ# 0025426 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000075
ODS 8567 (Rev. 12/97) 1111111111/ADCR/03 NOTICE TYPE: WP06A3

Client Notice: WP06-A4

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	December, 1997

Description of Notice:	LEAP Notice - not enrolled
Assistance Categories:	ADC
Hearing Rights:	No
Program ID:	GWP042
Transaction ID:	WPLM
Frequency:	Daily
Volume (est. monthly):	800
Form Number:	DHS 8567

Notes:

0000006 WMAW 2661

FRANKLIN CO COC COUNTY DEPT OF HUMAN SERVICES
80 E. FULTON ST.

COLUMBUS OH 432150000

IMPORTANT NOTICE

As of 05/12/1998 you have used 08 months of your initial 36 months of Ohio Works First benefit eligibility. If you continue to be eligible, you have 28 months remaining. After you have used up your 36 months, you might be eligible for additional months. See your caseworker.

JANE DOE
111 MAIN ST.

ANYWHERE, USA 11111-1111

Mailing Date: 05/13/1998
From: MARGARET A ROLLAND
Phone: (614) 462-5634 Ext:

Worker ID: WMAW25
Case Number: 1111111111
AG Name: JANE DOE

Dear JANE DOE

The school (GED-GLENWOOD CENTER) reported that JANE DOE is not enrolled at this school.

If you did not enroll in this school or provide proof of enrollment and you did not have "good cause", then your family's regular **ADCR** check will be reduced by $62.00. In addition, you will not be eligible for the $62.00 attendance bonus. Your family's **ADCR** check will be reduced every month until you meet the **LEAP** Program attendance rules or you become exempt from the **LEAP** Program.

Read all pages of this form. If you want to claim "good cause", fill out the information requested. You and the assistance group payee need to sign it. Then return the form within seven days of the mailing date with any proof requested to us at the above address.

We must receive this form by 05/20/1998. If we do not receive this form by this date, we will assume that you did not have good cause for not being in school. If you did not have good cause, the penalty will be applied. We will send your family another notice before any penalty is taken.

Any action we take based on your attendance will affect your family's JUNE, 1998, ADCR check.

KEEP READING >>>

SEQ# 0025510 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000006
ODS 8567 (Rev. 12/97) 1111111111/ADCR/01 NOTICE TYPE: WP06A4

READ PAGE ONE OF THIS FORM FIRST. THEN READ THIS PAGE AND THE NEXT PAGE. IF YOU WANT TO CLAIM GOOD CAUSE, FILL OUT PAGE TWO AND THREE. RETURN THIS FORM TO US BY 05/20/1998.

Check any of these boxes that apply to you. Write the date of the absence beside the reason that applies. There is a space at the bottom for you to write more information.

☐ _____ Date(s) I am attending a different school. (Provide Proof.)

☐ _____ Date(s) I have already graduated from high school or have received a **GED** certificate. (Provide proof.)

☐ _____ Date(s) I did not have transportation to school or child care. (Explain below.)

☐ _____ Date(s) I was not able to get child care for my child. (Explain below.)

☐ _____ Date(s) I was ill or injured and was unable to attend school. (Explain below. If you went to a doctor, provide proof.)

☐ _____ Date(s) My child was ill or injured and I needed to stay home and care for my child. (Explain below. If you went to a doctor, provide proof.)

☐ _____ Date(s) _____ (name of relative and relationship) was ill or injured and I needed to stay home to care for this person.

☐ _____ Date(s) A member of my family died. (Tell us who and when below.)

☐ _____ Date(s) I was not in school because either I or my child had a medical appointment. (Explain below and provide proof.)

☐ _____ Date(s) I was not in school because I had an appointment at the county department of Human Services. (Explain below.)

☐ _____ Date(s) I was not in school because either I or my child had to appear in court during school hours. (Explain below.)

☐ _____ Date(s) I was not in school for other reasons. (Explain below.)

☐ _____ Date(s) I was in class on the day(s) that the school reported I was absent. (Explain below.)

GIVE INFORMATION HERE TO HELP IN DECIDING IF YOU HAD 'GOOD CAUSE' FOR NOT GOING TO SCHOOL.

Signature of Teen		
SIGNATURE	DATE	TELEPHONE NUMBER

Assistance Group Payee's Signature		
SIGNATURE	DATE	TELEPHONE NUMBER

IF YOU NEED HELP SO THAT YOU CAN ATTEND SCHOOL (CHILD CARE, TRANSPORTATION, PARENTING CLASSES), CONTACT THE WORKER ON THE FIRST PAGE.

END

Client Notice: WP06-A5

A client notice name is composed of the **Notice Type**, which is four characters, and an **Action Code**, two characters.

CSR Number:	N/A
Date Implemented:	N/A
Last Date Revised:	December, 1997

Description of Notice:	LEAP Notice - no verification of enrollment
Assistance Categories:	ADC
Hearing Rights:	No
Program ID:	GWP042
Transaction ID:	WPLM
Frequency:	Daily
Volume (est. monthly):	1200
Form Number:	DHS 8567

Notes:

0000023 WLLU 1014

STARK COUNTY JO COUNTY DEPT OF HUMAN SERVICES
301 PIEDMONT AVE., NE

CANTON OH 447020000

IMPORTANT NOTICE

As of 05/12/1998 you have used 08 months of your initial 36 months of Ohio Works First benefit eligibility. If you continue to be eligible, you have 28 months remaining. After you have used up your 36 months, you might be eligible for additional months. See your caseworker.

JOHN DOE
111 MAIN ST.

ANYWHERE, USA 11111-1111

Mailing Date: 05/13/1998
From: LORNA L ULRICH
Phone: (330) 580-4648 Ext:

Worker ID: WLLU76
Case Number: 1111111111
AG Name: JANE DOE

Dear JANE DOE

Our records show that JOHN DOE has not provided proof of enrollment in school.

If you have failed to enroll in school or provide proof of enrollment and you did not have "good cause", then your family's regular **ADCU** check amount will be reduced by $62.00. In addition, you will not be eligible for the $62.00 attendance bonus. Your family's **ADCU** check will be reduced every month until you meet the **LEAP** Program attendance rules or you become exempt from the **LEAP** Program.

Read all pages of this form. If you want to claim "good cause", fill out the information requested. You and the assistance group payee need to sign it. Then return the form within seven days of the mailing date with any proof requested to us at the above address.

We must receive this form by 05/20/1998. If we do not receive this form by this date, we will assume that you did not have good cause for not being in school. If you did not have good cause, the penalty will be applied. We will send your family another notice before any penalty is taken.

Any action we take based on your attendance will affect your family's JUNE, 1998, ADCU check.

KEEP READING >>>

SEQ# 0025519 THIS SPACE FOR OFFICIAL USE ONLY PRINT SEQ. 0000023
ODS 8567 (Rev. 12/97) 1111111111/ADCU/01 NOTICE TYPE: WP06A5

READ PAGE ONE OF THIS FORM FIRST. THEN READ THIS PAGE AND THE NEXT PAGE. IF YOU WANT TO CLAIM GOOD CAUSE, FILL OUT PAGE TWO AND THREE. RETURN THIS FORM TO US BY 05/20/1998.

Check any of these boxes that apply to you. Write the date of the absence beside the reason that applies. There is a space at the bottom for you to write more information.

☐ _____ Date(s) I am attending a different school. (Provide Proof.)

☐ _____ Date(s) I have already graduated from high school or have received a **GED** certificate. (Provide proof.)

☐ _____ Date(s) I did not have transportation to school or child care. (Explain below.)

☐ _____ Date(s) I was not able to get child care for my child. (Explain below.)

☐ _____ Date(s) I was ill or injured and was unable to attend school. (Explain below. If you went to a doctor, provide proof.)

☐ _____ Date(s) My child was ill or injured and I needed to stay home and care for my child. (Explain below. If you went to a doctor, provide proof.)

☐ _____ Date(s) _____ (name of relative and relationship) was ill or injured and I needed to stay home to care for this person.

☐ _____ Date(s) A member of my family died. (Tell us who and when below.)

KEEP READING >>>

☐ _____ Date(s) I was not in school because either I or my child had a medical appointment. (Explain below and provide proof.)

☐ _____ Date(s) I was not in school because I had an appointment at the county department of Human Services. (Explain below.)

☐ _____ Date(s) I was not in school because either I or my child had to appear in court during school hours. (Explain below.)

☐ _____ Date(s) I was not in school for other reasons. (Explain below.)

☐ _____ Date(s) I was in class on the day(s) that the school reported I was absent. (Explain below.)

GIVE INFORMATION HERE TO HELP IN DECIDING IF YOU HAD 'GOOD CAUSE' FOR NOT GOING TO SCHOOL.

Signature of Teen		
SIGNATURE	DATE	TELEPHONE NUMBER

Assistance Group Payee's Signature		
SIGNATURE	DATE	TELEPHONE NUMBER

IF YOU NEED HELP SO THAT YOU CAN ATTEND SCHOOL (CHILD CARE, TRANSPORTATION, PARENTING CLASSES), CONTACT THE WORKER ON THE FIRST PAGE.

END

Helpful information about the

MEDICAID "SPENDDOWN" PROGRAM

We have enrolled you in the Medicaid Spenddown program. The preceding "Important Notice" tells your monthly Spenddown amount.

In the Spenddown program you are responsible for part of your medical expenses each month. This is your monthly Spenddown amount. You will get a Medicaid card every month that you meet your Spenddown.

Here are some questions and answers about the Medicaid Spenddown program.

HOW CAN I MEET MY SPENDDOWN FOR A MONTH?

To meet Spenddown you must have medical expenses for the month that equal your monthly Spenddown amount. You may do this in different ways.

(1) You may **pay** bills for medical services that you get in the month. A friend, relative or agency may also pay the bills for you. You may also use medical bills, or parts of bills, not covered by insurance whether or not you have paid them.

(2) You may **"incur"** bills for medical servcies that you get in the month. You "incur" a bill when you get a medical services and are responsible to pay for it later. You may use old bills for medical services you got in past months as long as you still owe the bill and the bill has not been used to meet Spenddown before.

If you want, in the same month
you may meet spenddown by (1) paying some bills and also (2) "incurring" other bills.

- OR -

(3) You may **"pay-in"** your spenddown amount for the month. You "pay-in" when you give your County Department a check or money order for your monthly Spenddown amount. A friend, relative or agency may also pay-in or pre-pay for you. (This is also called "pay in Spenddown" or "pre-pay Spenddown.")

HOW CAN I GET MY MEDICAID CARD AFTER I MEET MY SPENDDOWN?

It depends on how you meet your Spenddown for the month.

If you **pay and/or incur** bills for medical services for the month, give proof of your expenses to your county caseworker. (Examples of proof: bills, statements, invoices, receipts, etc.) After your caseworker has proof showing that you have met your Spenddown amount for the month, the state will mail your Medicaid card to you. After you give proof to your caseworker, you should get your card within 5 working days. Your card will be good from the day you met Spenddown through the last day of the month.

KEEP READING >>>

If you **pay-in** your Spenddown amount to your County Department for the month, your card will be good for the entire month. Ask your caseworker about how and when you may pay-in. (This is also called "pre-pay.")

If you need to show that you are on Medicaid before you get your Medicaid card, call your caseworker.

WHAT ELSE SHOULD I TELL MY CASEWORKER?

It is very important to tell your caseworker if you have:

(1) Unpaid medical bills that you owe;
(2) Expenses for medical items or services that you need every month;
(3) Medical insurance (coverage, premiums, co-payments, deductibles, etc.);
(4) Medicare Part A or Part B;
(5) Family members who have medical expenses or unpaid medical bills;
(6) SSI benefits and earnings or if you lost SSI due to earnings. (Ask your case worker and Social Security about "1619 Medicaid.")
(7) Changes in your household's circumstance such as income, resources, household size, address, etc.

These things may help you meet or lower your Spenddown amount, or even help you get Medicaid without any Spenddown.

WILL MEDICAID PAY FOR MY MEDICARE COSTS?

Yes, if you are now on Medicare and your income is low enough. Tell your caseworker if you have Medicare, or when you get on Medicare.

You may be eligible for one of the Medicare "buy-in" programs known as QMB, SLMB, or QI-1. The QMB program pays your Medicare premiums, plus your coinsurance and deductibles. The SLMB and QI-1 programs pay only your Part B premium. You cannot meet your Spenddown with expenses paid by these programs.

WHAT IF I GET FOOD STAMPS?

You may get more Food Stamps if you have medical expenses over $35 each month. This may include expenses you use to meet your Spenddown. Tell your caseworker about your medical expenses.

We hope this information is helpful. If you have questions, talk with your caseworker or call the Ohio Medicaid Consumer Hotline at 1-800-324-8680 (a free call).

KEEP READING >>>

INTRODUCTION

OVERVIEW OF THE CLIENT NOTICE SYSTEM

CRIS-E prints and mails anywhere from 25,000 to 150,000 notices on a daily basis. At certain times, such as the running of a weekend mass change, over 300,000 notices are printed and mailed.

The CRIS-E system creates a written notification to recipients whenever an eligibility event occurs that has a bearing on a recipient's eligibility, e.g., a denial, an approval or a change in the makeup of the assistance group. Client notices are also generated to notify recipients of non-eligibility related events, e.g., a change of caseworker.

Once a notice has been created, a record of it is stored in notice history. A list of the notices that have been sent for a specific case, as well as key details about each notice, is available via CRIS-E online transactions CNHS and CNHD. Reprints of notices can be requested via CNHD, which allows the user to have the notice sent to the recipient or to the reprint requestor at the CDHS.

The CRIS-E notice system is designed to combine any number of different notifications on a single notice. As an example, one AE01 notice may include information about a Food Stamp approval, an ADCR denial and a Medicaid approval. The notice examples in this book, for the purpose of clarity, include only 1 such 'action'. We currently have 129 different actions that reflect our 129 notices. This number is subject to constant change as new notices are added and old notices are deleted.

Requests for notices are generated by both online and nightly batch processes. During the day, certain actions entered by workers on the online system result in the creation of notice requests that are accumulated throughout the day. At night, the accumulated online notice requests are combined with batch notice requests and are processed for next-day mailing. The notices are both printed and mailed from Columbus.

ASSISTANCE GROUP CATEGORY CODES

CATEGORY	DESCRIPTION
ADCR	Regular ADC (Absent parent)
ADCI	Incapacitated Parent ADC
ADCU	Unemployed Parent ADC
ADCP	Refugee member within an eligible ADCR, ADCI, or ADCU SFU
GAU	Unemployed GA
GAA	Disability Assistance (DA)
GAI	3 month Presumptive
GAP	Refugee Member GA
MAA	Aged Medicaid
MAB	Blind Medicaid
MAC	ADC Medicaid
MAD	Disability Medicaid
MAG	GA Medical
MAH	ADC failed due to Stepparent Income Medicaid
MAJ	Home and Community Based Services Medicaid
MAL	Qualified Medicaid Beneficiary
MAM	Maintenance Need Allowance (MNA)
MAO	OSS Medicaid
MAP	ADC Healthy Start
MAQ	Medical Refugee Member without other MA Assistance
MAS	ADC failed due to Sibling Income Medicaid
MAT	ADC less than 21 Medicaid
MAV	ADC failed due to loss of dependent care disregard Medicaid
MAW	ADC failed due to less od 30 or 1/3 disregard Medicaid
MAX	ADC failed due to Sibling Income Earmarked Memebers Medicaid
MAY	Transitional Medicaid due to income earned/hrs or loss of 30 and 1/3 disregard
MAZ	Expedited Medicaid
MAAP	Aged, Refugee Medicaid
MABP	Blind, Refugee Medicaid
MACP	ADC, Refugee Medicaid
MADP	Disability Refugee Medicaid
MAGP	GA, Refugee Medical
MAHP	ADC failed due to Stepparent Income Medicaid (Refugee in SFU)
MALP	Qualified Medicaid Beneficiary, Refugee Medicaid
MAMP	Refugee Maintenance Need Allowance (MNA)
MAOP	OSS Medicaid, Refugee

(cont'd)

MAPP	ADC Refugee Healthy Start
MASP	ADC, Refugee failed due to Sibling Income Medicaid
MATP	ADC, Refugee less than 21 Medicaid
MAUS	
MAVP	ADC failed due to loss of dependent care disregard Medicaid(Refugee in SFU)
MAWP	ADC failed due to less od 30 or 1/3 disregard Medicaid (Refugee in SFU)
MAXP	ADC failed due to Sibling Income Earmarked Memebers Medicaid(Refugee in SFU)
MAZP	Expedited Refugee Medicaid

NOTICE TYPES AND ACTIONS BY TRANSACTION ID

Transaction ID: AEWAU

AE01A1	AE01AM	AE04C1	AE21A1
AE01A2	AE01AN	AE04I1	AE21A2
AE01A3	AE01C1	AE04I2	AE21A3
AE01A4	AE01D1	AE04I3	AE21A4
AE01A5	AE01D2	AE04M1	AE21D1
AE01A6	AE01I1	AE04R1	AE21D2
AE01A7	AE01I2	AE04R2	AE21D3
AE01A8	AE01I3	AE04R3	AE22A1
AE01A9	AE01M1	AE04T1	AE22A2
AE01AA	AE01R1	AE04T2	AE22D3
AE01AB	AE01R2	AE04X2	AE24C1
AE01AC	AE01R3	AE07TM	AE24L1
AE01AD	AE01T1	AE09M1	AE24L2
AE01AE	AE01T2	AE10M1	CM05R1
AE01AF	AE01X2		

Transaction ID: CU023

BI01X1	BI01X2	BI01X5

Transaction ID: BVCP

BV05O1	BV13O1	BV20O1	BV31O1
BV07O1	BV15O1	BV21O1	BV32O1
BV12O1	BV16O1	BV30O1	BV33O1

Transaction ID: SC002

EZ01C1	EZ03D1	EZ04N1	EZ04N2
EZ02C1			

Transaction ID: MC020

MC01C1	MC01I3	MC01R3	MC01T3
MC01I1	MC01R1	MC01T1	
MC01I2	MC01R2		

(cont'd)

Transaction ID: PRUS

PR01A1	PR01A3	PR01A4	PR01A5
PR01A2			

Transaction ID: WPLT

WP06A1	WP06A2	WP06A3

Transaction ID: WPLM

WP06A4	WP06A5

The remaining notices are not dependent on a transaction ID:

AE01Z1	BV04A5	CM04P1	HM01N1
AE01Z2	BV04A6	CS01C2	HM02N1
AR01J1	BV04A7	CS02C3	HM02N2
AR02J2	BV60A1	CS03C4	WP02W2
AR03J3	BV61A1	CS04A1	WP03W3
BV04A1	BV62A1	DE01B1	
BV04A2	BV63A1	DE02B2	
BV04A3	BV64A1	DE02B3	
BV04A4	CM01E1	DE03B4	

HEARING RIGHTS AND NON-HEARING RIGHTS NOTICES

The following notices include a hearing rights page that informs the client of the right to a State Hearing:

AE01A1	AE01I2	AE10M1	BV13O1
AE01A2	AE01I3	AE21A1	BV15O1
AE01A3	AE01M1	AE21A2	BV16O1
AE01A4	AE01R1	AE21A3	BV20O1
AE01A5	AE01R2	AE21A4	BV21O1
AE01A6	AE01R3	AE21D1	BV30O1
AE01A7	AE01T1	AE21D2	BV31O1
AE01A8	AE01T2	AE21D3	BV32O1
AE01A9	AE01X2	AE22A1	BV33O1
AE01AA	AE01Z1	AE22A2	DE01B1
AE01AB	AE01Z2	AE22D3	DE02B2
AE01AC	AE04C1	AE24C1	DE02B3
AE01AD	AE04I1	AE24L1	DE03B4
AE01AE	AE04I2	AE24L2	MC01C1
AE01AF	AE04I3	AE25L1	MC01I1
AE01AM	AE04M1	AR04D1	MC01I2
AE01AN	AE04R1	BI01X1	MC01I3
AE01C1	AE04R2	BI01X2	MC01R1
AE01D1	AE04R3	BI01X5	MC01R2
AE01D2	AE04T1	BV05O1	MC01R3
AE01H1	AE04T2	BV07O1	MC01T1
AE01I1	AE04X2	BV12O1	MC01T3

The following notices do not include notification of Hearing Rights:

AE05F1	BV04A5	BV74A1	EZ03D1	PR01A4
AE07TM	BV04A6	CM01E1	EZ04N1	PR01A5
AE09M1	BV04A7	CM03N1	EZ04N2	PR01AA
AR01J1	BV60A1	CM04P1	HM01NP	WP02W2
AR02J2	BV61A1	CM05R1	HM01NV	WP03W3
AR03J3	BV62A1	CS01C2	HM01N1	WP06A1
BI02N1	BV63A1	CS02C3	HM02N1	WP06A2
BV04A1	BV64A1	CS03C4	HM02N2	WP06A3
BV04A2	BV70A1	CS04A1	PR01A1	WP06A4
BV04A3	BV71A1	EZ01C1	PR01A2	WP06A5
BV04A4	BV72A1	EZ02C1	PR01A3	

NOTICES LISTED WITH THEIR ASSISTANCE GROUPS

Client Notice	Category
AE01A1	MA (and not OSS); MA-O
AE01A2	FS
AE01A3	MA(Y,C,H,P,Q,S,T,V,W,X,Z,G), MA(YP,CP,HP,PP, SP,TP,VP,WP, XP, ZP), MAGP
AE01A4	ADC, GA, MA (OSS only)
AE01A5	ADC, MA (OSS only)
AE01A6	MA
AE01A7	MA
AE01A8	FS
AE01A9	FS
AE01AA	MA
AE01AB	MA-L, -P
AE01AC	MA-L, -P
AE01AD	MA-A, -AP, -B, -BP, -D -DP
AE01AE	MA-A, -AP, -B, -BP, D -DP
AE01AF	All MA except MA-M and MA-Z
AE01AM	MAUS
AE01AN	MAUS
AE01C1	MA-A, -B, -D, -L
AE01D1	All except GA-A, -U, MA-Z, -G
AE01D2	MAUS
AE01H1	ADC, GA, MA
AE01I1	ADC, GA, FS, MA (OSS)
AE01I2	MA (A, B, D, L, J)
AE01I3	MA (A, B, D, L, D)
AE01M1	MA-Y,-C,-H,-P,-Q,-S,-T,-V,-W,-X,-Z,-G, MAYP, -CP,-HP,-PP,-SP,-TP,-VP,-WP,-XP,-ZP,MAGP, ADC, GA
AE01R1	All AGs
AE01R2	MA only
AE01R3	MA (A, B, D)
AE01T1	All but MAA, MAB & MAD w/spenddown > 0
AE01T2	MA (A, B, D, L) with spenddown amount > 0
AE01X2	ADC, GA, FS, MA (OSS)
AE01Z1	ALL AG'S
AE01Z2	FOOD STAMPS & ADC (OWF)
AE04C1	MAA, MAB, MAD, MAL
AE04I1	ADC, GA, FS, MA (OSS)

(cont'd)

AE04I2	MA (A, B, D)
AE04I3	MA (A, B, D)
AE04M1	ADC, GA, FS, MA(Y,C,H,P,Q,S,T,V,W,G,X, Z,MAYP,CP,HP,PP,SP,TP,VP, WP, XP, ZP, GP)
AE04R1	All
AE04R2	MA only
AE04R3	MA (A, B, D)
AE04T1	All AG's except MAA, MAB & MAD;MA C, MACP
AE04T2	MA (A, B, D, L) with spenddown amount > 0
AE04X2	ADC, FS, MA(OSS)
AE05F1	All
AE07TM	MAY, MAYP
AE09M1	MA-A, -AP, -B, -BP, D -DP
AE10M1	MAZ, MAZP
AE21A1	MA-G
AE21A2	GA-A
AE21A3	GA-A
AE21A4	GA-A
AE21D1	ADC, GA
AE21D2	MA-G
AE21D3	GA-A, MA-G
AE22A1	GA-U
AE22A2	MA-G
AE22D3	GA-U
AE24C1	MA C
AE24L1	ADCI, ADCP, ADCQ, ADCR, ADCU, MA Y, MAYP,MA C, MACP, MA H, MAHP, MA P, MAPP, MA Q, MA S, MASP, MA T
AE24L2	ADCI, ADCP, ADCR, ADCQ, ADCU
AE25L1	
AR01J1	APPL's only
AR02J2	APPL's only
AR03J3	APPL's only
AR04D1	APPL's only
BI01X1	All
BI01X2	All
BI01X5	All
BI02N1	All

(cont'd)

BV04A1	ADC, FS, GA
BV04A2	ADC, FS, GA
BV04A3	GA
BV04A4	open FS with claim type IPV or IHE
BV04A5	(closed FS with claim type IPV or IHE).
BV04A6	open FS with claim type IPV or IHE
BV04A7	closed FS with claim type IPV or IHE; All ADC, GA
BV05O1	All
BV05O1	All
BV07O1	ADC, GA, DA
BV12O1	ADC
BV13O1	ADC
BV15O1	ADC
BV16O1	ADC
BV20O1	GA, DA
BV21O1	GA, DA
BV30O1	FS
BV31O1	FS
BV32O1	FS
BV33O1	ADC,FS
BV60A1	FS
BV61A1	
BV62A1	
BV63A1	FS
BV64A1	FS
CM01E1	FS
CM02E2	FS
CM03N1	All
CM04P1	All AGs.
CM05R1	MA-A, -AP, -B, -BP, D -DP
CS01C2	All AGs
CS02C3	All AGs
CS03C4	All AGs
CS04A1	All AGs
DE01B1	ADC
DE02B2	ADC
DE02B3	ADC
DE03B4	ADC
EZ01C1	FS

EZ02C1	FS
EZ03D1	FS
EZ04N1	FS

(cont'd)

EZ04N2	FS
HM01N1	MA C, MA H, MA P, MA S, MA T, MA V, MA W, MA X, MA Y
MC01C1	All AGs except FS, MAM, MAG, MAMP, MAGP
MC01I1	All AGs except MAA, MAAP, MAB, MABP, MAD, MADP, MAM,
MAG,	MAMP, MAGP
MC01I2	MAA, MAB, MAD AGs only
MC01I3	MAA, MAB, MAD AGs only
MC01R1	All AGs except MAA, MAAP, MAB, MABP, MAD, MADP, MAM, MAMP, MAG, MAGP
MC01R2	MAA, MAB, MAD AGs only
MC01R3	MAA, MAB, MAD AGs only
MC01T1	All AG's except MAM, MAG, MAMP, MAGP
MC01T3	All MA except MA M, MAMP, MA G, MAGP

PR01A1
PR01A2
PR01A3
PR01A4
PR01A5
PR01AA

WP02W2	ADC, FS, GA
WP03W3	ADC, FS, GA
WP06A1	ADC
WP06A2	ADC
WP06A3	ADC
WP06A4	ADC
WP06A5	ADC

Client Notice Element Definitions

Notice Type - This is part of how a notice is unique. The first two letters indicate what subsystem that the notice comes from. The following are a list of the subsystems:

AE - Application Entry
BI - Benefit Issuance
CM - Caseload Management
DE - Data Exchange
MC - Mass Change
WP - Work Programs
AR - Application Registration
BV- Benefit Recovery
CS - Client Schedule
EZ - Expedited Medicaid
PR - Periodic Reporting

Action - This is the second part of how a notice is unique. A change has been proposed or has occurred in the recipients Public Assistance situation.

Program ID - The computer program executes a request to create a notice.

Description of Notice - Tells what purpose the notice is to be serving for the client.

Hearing Rights - The notice comes with a hearing rights page, which gives the client an option to contest what the notice stated.

Assistance Group(s) - Tells what group of individuals should be getting this notice.

Frequency - Tells how often this notice goes out.

Volume - A monthly estimate of how many times this notice gets mailed out to clients.

Transaction ID - Triggers the notice to be generated.

Date Implemented - The date in which the live notice was first run through the system.

Form Number - A tracking number that is assigned to a notice before being distributed to the client.

Last Date Revised - Date of last change.

CSR Number - The assignment id of the project that included the request of this notice.

Notes - General Information concerning the notice.