Reset Form

Ohio Department of Job and Family Services

STATE HEARING REQUEST

Complete in duplicate.

Name of Appellant ***(Last, Frist, Middle)***	Assistance Group Number ***(if known)*** Or Social Security Number
Street Address	Program
City, State and Zip Code	County

Date of Action Appealed	Date Notice Issued

This appeal is in relation to the action (or lack of action) by the _____
(name of local agency)

I want a hearing because:

Signature	Telephone Number	Date

We must receive your request for a state hearing with 90 calendar days from the mailing date of the notice of the agency's 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.
Note: The preceding also applies to medical assistance providers. Therefore, hearing requests cannont be accepted from medical providers unless accompanied by the individual's written authorization.

Distribution: Original to the Ohio Department of Job and Family Services, Bureau of State Hearings, P.O. Box 182825, Columbus, Ohio 43218-2825, one copy to local agency.