Ohio Department of Job and Family Services

PRIOR NOTICE OF RIGHT TO A STATE HEARING

Name	Case Name	
Street Address	Case Number	Program
City, State, and Zip Code	County	Mailing Date

We are proposing to make the following changes in your assistance. If you do not agree with this proposal and request a hearing by __________________ this action will not be taken until the state hearing is decided. (For a full explanation of your hearing rights, see the second page of this notice.)

Termination of Benefits:

☐ The following benefits will be stopped:

- ☐ Your __________benefit will stop on _________________.
- ☐ Your SNAP benefit will stop on _____________________.
- ☐ Your Medicaid will stop on _________________________.

☐ The following services will stop on ____________

Services:

Reduction of Benefits:

☐ The following benefits will be reduced:

- ☐ Your ____________ benefit be reduced from $_________ to $______________ on _________________.
- ☐ Your SNAP benefit will be reduced from $ _____________ to $____________ on _____________.

☐ The __________________ allowance will be reduced from $ _____________ to $______________ on ______________.

☐ The following services will be reduced from $______ to _______________ on ______________________.

Services:

Suspension, Increase or Change in Benefits:

☐ The following action will be taken:

- ☐ Your ________________ benefit will be increased from $_____________ to $_____________ on ________________.
- ☐ Your Medicaid card for the month of ___________________________________ will be held and not mailed.
- ☐ Your _______________________________ benefit will be suspended effective _______________________________.

☐ Your Medicaid will be suspended effective _______________________________.

☐ Other *(explain)*:

The reasons for this proposed action are:

The rules that require this action are:

If you do not understand this proposed action or you want to talk to your caseworker about it, you may call:

Caseworker	District/ID	Telephone Number

Case Name	Case Number	Mail Date

Your Right to a State Hearing

If you disagree with this action, you have the right to a state hearing. A state hearing lets you or your representative (lawyer, friend or relative) give your reasons against this action. The agency proposing the action will also attend the hearing to present its reasons. A hearing officer from the Ohio Department of Job and Family Services will decide whether you or the county agency is right. If you win your hearing the action may not be taken or you could get an increase in your benefits. If you lose your hearing, you may have to pay back money or food stamps that you received but were not eligible to receive. **You do not need to return this form if you agree with the proposed 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 contact your local Legal Aid office in Ohio by calling 1-866-529-6446.

I want a state hearing.

Signature	Date	Telephone Number

Fill out this information, only if applies to your situation. *(Check all that apply)*

- ☐ I want to do my hearing by telephone. The phone number to call is ______________________.
- ☐ I need an interpreter at my state hearing. The language needed is ______________________ .
- ☐ I am not available for a hearing on ______________________________
  (Please note: ODJFS may not be able to give you the preferred date.)
- ☐ I want a County Conference. (This is a meeting to discuss your case with your local agency.)
- ☐ This person has agreed to help me with my state hearing (my "authorized representative")

Name		Telephone Number ( )
Address		Fax ( )
City, State, Zip	Email	

ODJFS must receive your request 90 days from the date this notice was mailed to you. You must choose one of the following ways to send this state hearing request to us. You should keep proof of when and how you sent this hearing request to us.

Please only submit your hearing request one time and include both pages of this notice.

Electronically - Submit the hearing request to the Bureau of State Hearings SHARE Portal at https://hearings.jfs.ohio.gov/SHARE Log into the SHARE Portal using your Ohio Benefits ID and password to submit your request. (If you do not have an Ohio Benefits account, sign up at ssp.benefits.ohio.gov); or
Email - Email the ODJFS Bureau of State Hearings at bsh@jfs.ohio.gov. In the subject, put "State Hearing Request". In the message, put all of the information from the boxes at the top of this page and any additional information below; or
Phone - Phone the ODJFS Consumer Access Line at 866-635-3748. Follow the instructions for State Hearings. Mention this notice; or
Fax - Fax **both pages** of this notice to the ODJFS Bureau of State Hearings at (614) 728-9574; or
Mail - Mail **both pages** of this notice to ODJFS Bureau of State Hearings, P.O. Box 182825, Columbus, Ohio 43218-2825.
Contact your caseworker – It is better to send this request using one of the other methods above. But, you may give this page (completed and signed) to your caseworker. Or, you may phone your caseworker. Mention this notice.