# OSAH FORM 1

| OSAH USE ONLY: | AGENCY DFCS | CASE TYPE | DOCKET NUMBER | COUNTY | JUDGE |
|---|---|---|---|---|---|
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## DEPARTMENT OF HUMAN SERVICES
## DIVISION OF FAMILY & CHILDREN SERVICES
## NON-MEDICAID PUBLIC ASSISTANCE

| Applicant/Recipient's County of Residence: | Date Hearing Request Filed with Agency: | Agency Reference Number: |
|---|---|---|
| | | |

**Check here if an application was DENIED:** ☐

**Check here if benefits were REDUCED/TERMINATED:** ☐

**Check here if the LEVEL OF ASSISTANCE is disputed:** ☐

**Check Only One:**

| | |
|---|---|
| ☐ **CAPS** (Childcare and Parent Services) | ☐ **SAA** (State Adoption Assistance) |
| ☐ **FCDP** (Foster Care Due Process) | ☐ **TANF** (Temporary Assistance for Needy Families) |
| ☐ **FOST PLACE** (Foster Care Placement or Visitation Issues) | ☐ **TIFS** (Tax Intercepts of Federal And State Refunds) |
| ☐ **FSP** (Food Stamp Program) | |

**For FSP cases, check here if Applicant/Recipient requires notice of hearing in Spanish:** ☐

**APPLICANT/RECIPIENT**

| | | |
|---|---|---|
| **NAME:** | TEL #: | FAX #: |
| CURRENT ADDRESS INCLUDING ZIP CODE: | | EMAIL: |
| **ATTORNEY'S NAME (IF APPLICABLE):** | TEL #: | FAX #: |
| ADDRESS INCLUDING ZIP CODE: | GEORGIA BAR #: | EMAIL: |
| **PERSONAL REPRESENTATIVE'S NAME (IF APPLICABLE):** | TEL #: | FAX #: |
| CURRENT ADDRESS INCLUDING ZIP CODE: | RELATIONSHIP TO A/R: | EMAIL: |

**LOCAL DFCS OFFICE**

| | | |
|---|---|---|
| **NAME OF OFFICE:** | TEL #: | FAX #: |
| ADDRESS INCLUDING ZIP CODE: | CASEWORKER'S NAME:<br>CASEWORKER'S DIRECT TEL #:<br>EMAIL: | SUPERVISOR'S NAME:<br>SUPERVISOR'S DIRECT TEL #:<br>EMAIL: |
| **REGIONAL HEARING COORDINATOR** (NAME AND ADDRESS): | COORDINATOR'S DIRECT TEL #: | FAX #:<br>EMAIL: |

*****COPIES OF ADVERSE ACTION LETTER AND HEARING REQUEST MUST BE ATTACHED*****

**This form is available online at http://www.osah.ga.gov or by telephone request at (404) 657-2800.**

**(OSAH 08/2016)**