**OSAH FORM 1**

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| **OSAH USE ONLY:** | AGENCY  **DFCS** | CASE TYPE | DOCKET NUMBER | COUNTY | JUDGE |

**DEPARTMENT OF HUMAN SERVICES**

**DIVISION OF FAMILY & CHILDREN SERVICES**

**NON-MEDICAID PUBLIC ASSISTANCE**

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

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| --- |
| **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)  **CFSP** (Commodity Supplemental Food Program)  **FCDP** (Foster Care Due Process)  **FOST PLACE** (Foster Care Placement or Visitation Issues) | **FSP** (Food Stamp Program)  **SAA** (State Adoption Assistance)  **SBR** (SNAP Benefit Recovery)  **TANF** (Temporary Assistance for Needy Families)  **TIFS** (Tax Intercepts of Federal And State Refunds) |

**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:    CASEWORKER’S DIRECT TEL #:    EMAIL: | SUPERVISOR’S NAME:    SUPERVISOR’S DIRECT TEL #:    EMAIL: |
| **REGIONAL HEARING COORDINATOR** (NAME AND ADDRESS): | COORDINATOR’S DIRECT TEL #: | FAX #:    EMAIL: |

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