**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\*\*\***