

# OSAH FORM 1

<b>OSAH USE ONLY:</b>	<b>AGENCY DFCS</b>	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:
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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 <u>Only</u> One:	
<input type="checkbox"/> <b>CAPS</b> (Childcare and Parent Services) <input type="checkbox"/> <b>CFSP</b> (Commodity Supplemental Food Program) <input type="checkbox"/> <b>FCDP</b> (Foster Care Due Process) <input type="checkbox"/> <b>FOST PLACE</b> (Foster Care Placement or Visitation Issues)	<input type="checkbox"/> <b>FSP</b> (Food Stamp Program) <input type="checkbox"/> <b>SAA</b> (State Adoption Assistance) <input type="checkbox"/> <b>SBR</b> (SNAP Benefit Recovery) <input type="checkbox"/> <b>TANF</b> (Temporary Assistance for Needy Families) <input type="checkbox"/> <b>TIFS</b> (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:	SUPERVISOR'S NAME:
	CASEWORKER'S DIRECT TEL #:	SUPERVISOR'S DIRECT TEL #:
	EMAIL:	EMAIL:
REGIONAL HEARING COORDINATOR (NAME AND ADDRESS):	COORDINATOR'S DIRECT TEL #:	FAX #:  EMAIL:

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