Department of Job & Family Services

_____
_____
_____
_____

Case: _____
Name: _____
Mail Date: _____

_____
_____
_____
_____

Questions? Ask your worker

TDD-For Hearing Impaired 7-1-1
County Telephone _____
Office Hours _____

NOTICE ABOUT YOUR CASH ASSISTANCE, SNAP, AND/OR CHILD CARE BENEFITS

If you are unable to read English and need this notice translated into your preferred language, contact your case worker. Please call the number listed above for assistance.

If you believe you have been discriminated against or if your county agency has not provided you with an interpreter or a translation of this notice; and you wish to file a complaint, contact ODJFS Bureau of Civil Rights at 1-866-227-6353; the hearing-impaired may call TDD 7-1-1.

THIS NOTICE REQUIRES ACTION FROM YOU TO CONTINUE YOUR BENEFITS. PLEASE READ ALL PAGES.

Your Civil Rights:

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/ad-3027.pdf, from any USDA office, by calling (833) 620-1071, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to:

(1) mail: Food and Nutrition Service, USDA
1320 Braddock Place, Room 334
Alexandria, VA 22314; or

(2) fax: (833) 256-1665 or (202) 690-7442; or

(3) email: FNSCIVILRIGHTSCOMPLAINTS@usda.gov

This institution is an equal opportunity provider.

Please do not send information, such as applications or verifications, to the United States Department of Agriculture (USDA) address listed above. This address is for civil rights complaints only. Please send application materials or verifications to your local county JFS office.

PLEASE CONTINUE TO THE NEXT PAGE

Ohio Department of Job and Family Services

REQUEST TO REAPPLY FOR CASH ASSISTANCE, SNAP AND/OR CHILD CARE

VOTER REGISTRATION APPLICATION ATTACHED- ASSISTANCE AVAILABLE

If you are not registered to vote where you live now, would you like to apply to register to vote here today?

☐ **YES, I want to register to vote**
☐ **NO, I do not want to register to vote**

If you do not check either box, you will be considered to have decided not to register to vote at this time.

Case Number		
County Contact	County Contact Phone Number	County Contact Fax Number

It is time for you to reapply for _____. You must reapply in order to continue receiving benefits. For SNAP and cash assistance, you may also have to complete an interview. If you have to complete an interview, you received an appointment notice with this reapplication form.

Step 1: Read the information in this box and make corrections as necessary or tell us your information.

First Name Middle Initial and Last Name			
Mailing Address		Street Address *(if different)*	
City State Zip Code		City State Zip Code	
Email Address	Home Phone Number	Work Phone Number	Cell Phone Number

Step 2: Tell us about your HOUSEHOLD COMPOSITION

You must list everyone who lives with you even if they are not applying. Please be sure to list your name first. If you need more space, write your answers on an extra piece of paper and attach it to this form. **Please use the following to assist with completing the section below:**

- **Social Security Number:** If you, or anyone else in your household, is NOT a US citizen, or qualified non-citizen, you do not have to give us a Social Security Number.
- **U.S. Citizen:** You only have to tell us if someone is a US citizen if they are applying for SNAP, Cash, Medical or Child Care Assistance.

Race/Ethnicity: Title VI of the Civil Rights Act of 1964 allows us to ask for racial/ethnic (Hispanic or Latino) information. Providing this information is voluntary and is used for informational purposes only. If you do not want to give us this information, it will have no effect on your case.

Name	Relationship to You *(spouse, friend, etc.)*	Social Security Number	Sex	U.S. Citizen	Hispanic or Latino	Race	Move In / Move Out Date
			☐ M ☐ F	☐ Y ☐ N	☐ Y ☐ N		
			☐ M ☐ F	☐ Y ☐ N	☐ Y ☐ N		
			☐ M ☐ F	☐ Y ☐ N	☐ Y ☐ N		
			☐ M ☐ F	☐ Y ☐ N	☐ Y ☐ N		

Is anyone in your household in the military?
☐ **Yes** ☐ **No** If Yes, ☐ Active Duty ☐ National Guard/Reserve

Is anyone in your household a veteran who served in the Armed Forces or reserves?
☐ **Yes** ☐ **No**

Is anyone in your household pregnant?
☐ **Yes** ☐ **No -** If yes, who and when is the due date? _____

Is anyone in your household caring for a disabled person in or outside of the home?
☐ **Yes** ☐ **No -** If yes, who? _____

Is anyone in your household a participant in a resident or non-resident drug addiction or alcohol treatment and rehabilitation program?
☐ **Yes** ☐ **No -** If yes, who? _____

Is anyone in your household under 25 years old and who aged out of foster care?
☐ **Yes** ☐ **No -** If yes, who? _____

Is anyone in your household unhoused or homeless (i.e. does not have a fixed, regular nighttime residence or the residence is a shelter or institution that provides temporary living accommodations, or a temporary accommodation for not more than 90 days in the residence of another individual)?
☐ **Yes** ☐ **No -** If yes, who? _____

Is anyone in your household enrolled at least half-time in a school, training program or institution of higher education (i.e. a college or university or a business, technical or vocational school that requires a high school diploma/GED)?
☐ **Yes** ☐ **No -** If yes, who? _____

Is anyone in your home currently fleeing from felony prosecution, fleeing from high misdemeanor prosecution in New Jersey, violating conditions of probation or parole, or is determined to be convicted of and out of compliance with their sentence for the following crimes committed on or after February 7, 2014: aggravated sexual abuse, murder (18 U.S.C 1111); an offense under 18 U.S.C Chapter 10; a federal or state offense involving sexual assault, as defined in section 40002(a) of the Violence Against Women Act of 1994 (42 U.S.C. 13925(a)); or an offense under state law determined by the attorney general of the United States, to be substantially similar to the above crimes?

☐ **Yes** ☐ **No** ☐ **I am not sure**

Step 3: Tell us about your HOUSEHOLD RESOURCES *(ATTACH PROOF)*

How much do you and the people in your household have in cash, checking, or savings (such as bank accounts, annuities, stocks, or bonds)?

Give your best estimate of the total amount: $_____

Do you and the people in your household have more than one million total dollars in cash, checking, or savings (such as bank accounts, annuities, stocks, or bonds)? ☐ **Yes** ☐ **No**

Step 4: Tell us about your HOUSEHOLD INCOME INFORMATION *(ATTACH PROOF)*

If you or people in your household are expected to receive income* this month, please complete the table below.

***Income** means all the money that you and the people in your home receive. This includes earnings from employment or self-employment, child/spousal support, disability benefits, retirement benefits, Workers' Compensation, Unemployment Compensation, Social Security, SSI, Veterans Benefits, Ohio Works First, gifts of money from individuals, etc.

Name	**Type of Income or Name of Employer**	**How Often Received** *(weekly, bi-weekly, etc.)*	**Income Amount** *(before taxes)*	**Date Last Received**

Step 5: Tell us about your HOUSEHOLD EXPENSES *(ATTACH PROOF)*

Check all that apply. List the amount for each expense.

☐ **Child/Dependent Care Costs**
Estimated Amount Paid per Month: $_____

☐ **Child/Spousal Support Payments Made to Someone Outside Your Household**
Estimated Amount Paid per Month: $_____

☐ **Medical Expenses for Anyone Who is Disabled or Age 60 or Older.** These include expenses such as medical bills, prescriptions, health insurance premiums, transportation to medical appointments, or other medical services.
Estimated Amount Paid per Month: $_____

☐ **Rent, Mortgage Payments, Lot Rent, Property Taxes, Homeowners' Insurance, etc.**
Estimated Amount Paid per Month: $_____

Do you pay for heat or air conditioning? ☐ **Yes** ☐ **No**

I pay for the following utilities *(check all that apply)*:
☐ Telephone ☐ Trash ☐ Sewage ☐ Water ☐ Electric ☐ Gas

Step 6: Please read this information carefully.

To continue to get your benefits we must review your case to make sure that you are still eligible and that you are getting the correct amount of benefits. If you have questions, call your county agency listed at the top of this form.

Medical assistance: This form is not an approved application for medical assistance programs. Consumers should continue to reapply using approved medical assistance application forms. Any information provided during your interview will be used to update your case and may affect your medical assistance benefits.

If you are currently getting **SNAP** or **Cash** benefits:

Please sign and return this form to us by <insert Application Due Date> but no later than the <insert RE Date>. You may return this form to us by mail, fax, or by bringing it to us. If you bring it in, you will get a receipt.

If you have an account, you may also complete this form online at https://ssp.benefits.ohio.gov/apspssp/index.jsp.
To complete this process online:

- Sign into your account
- Click the "Access" section to the right of the screen
- Select "Reapplication" and follow the prompts

If we do not get this form back from you, we will stop your cash assistance and your SNAP will expire.
Remember reapplying for benefits has two steps: 1. Signing and returning this form and 2. Completing an interview, if required. You will have received an interview appointment notice with this reapplication form if you are required to do an interview.

If you are currently getting **Child Care**:

Your current child care eligibility is scheduled to end on _____ / _____ / _____. You must fill out this form and return it by _____ / _____ / _____. If we do not receive the completed form and all supporting documentation by the date your current eligibility ends, your child care assistance will be terminated and all authorizations to providers will be ended. If you do not have an eligibility end date listed, you do not need to reapply for child care benefits at this time.

Complete, sign and return this form to the county agency address, fax number or email address listed above, or if you have an account, complete it online at: https://ssp.benefits.ohio.gov/apspssp/index.jsp. If a question says ***ATTACH PROOF***, you **MUST** attach your proof to this form and submit it at the same time. If you need more space for your answers, write them on extra paper and attach them to this form. We will use the information you provide to determine your eligibility for the next eligibility period.

Step 7: Please read, complete and sign the section below

By signing this form:
- I understand the questions on this form and certify, under penalty of perjury, that all my answers for the cash assistance and SNAP

recertification interview, and/or the answers I provide on this form, are correct and complete to the best of my knowledge, including information about the citizenship or Qualified Non-Citizen status of each household member reapplying for SNAP and/or cash assistance, or for Child Care, the citizenship or Qualified Non- Citizen status of each child in need of care.

- I understand and agree to provide all documents to complete my telephone interview for cash assistance, SNAP, and/or Child Care.
- I understand and agree that the county JFS office may contact other persons or organizations to obtain the necessary proof of my eligibility and level of assistance and/or in some instances, I may be asked to give consent to the county JFS office to make those contacts.
- I have received a copy of, and I have read, my rights and responsibilities (JFS 07501), and I understand them. I agree to fulfill my responsibilities as required.
- I understand that my county JFS office will assist me in getting required verifications as long as I cooperate.
- I understand that information available through the Income Eligibility Verification System (IEVS) will be requested, used, and may be verified through collateral contacts when discrepancies are found that the information received may affect my household's eligibility for benefits.
- I understand that cash benefits are issued on the EPPICard. The EPPICard can be used at MasterCard member banks, ATMs and most retailers that accept MasterCard. It cannot be used at liquor stores, casinos, gaming establishments, or any retail establishments that provide adult oriented entertainment in which performers disrobe or perform in an unclothed state for your entertainment.
- I understand that SNAP benefits are issued on the Ohio Direction card and I am prohibited from using SNAP benefits to purchase or sell firearms or
- controlled substances.
- I understand that I can use SNAP benefits to only buy eligible items. I cannot use SNAP benefits to buy non-food items such as alcoholic drinks,
- tobacco, etc.
- I understand that I am prohibited from selling, trading or purchasing SNAP benefits and cannot use someone else's SNAP benefits for my household. I can be disqualified from the SNAP program for any of these violations.
- I understand that I must not give false information or hide information to get or continue to receive benefits. If you purposely gave wrong information during an interview, your benefits may be denied or terminated and legal action may be taken against you.
- I understand that if I receive SNAP benefits that I should not have gotten:
    - I may be ordered to repay the benefits.
    - I may be charged with fraud.
    - I may be fined (up to $250,000) or sent to prison (up to 20 years) or both.
    - I may be prohibited from receiving benefits in the future.
    - This information is found under the SNAP Penalty Warning section of the Program Enrollment and Benefit Information guide.
- I understand that my signature below gives the county agency permission to access available information in the Support Enforcement Tracking System (SETS) to verify my child / spousal / medical support income. My signature below also gives consent to issue a system-generated statewide student identifier (SSID) for each child on this application.
- I acknowledge and agree that my county JFS office may share certain details about the authorizations resulting from this application with the Child Care provider to which the child(ren) have been authorized for care, once the application is approved.
- I have received an explanation regarding the requirements for determining eligibility; the reasons why I may not be eligible; my right to a state hearing; and my responsibility for reporting changes to my county JFS office and the penalty, including possible civil action or criminal prosecution, for the intentional withholding or falsification of information or misuse of Child Care benefits, including misuse of the automated Child Care attendance tracking system.
- I understand that I will be able to use publicly funded Child Care benefits only for children who are eligible and only up to the maximum hours authorized by my county JFS office. To remain eligible for publicly funded Child Care benefits, any required copayment (if applicable) must be paid to the provider. Failure to pay the required copayment may result in termination of publicly funded Child Care benefits.
- I understand that if I am approved, I will be responsible for accurately recording my child's attendance at the Child Care program by utilizing an automated attendance tracking system. This includes registering in the system and creating personal identification information that I will use to access the system and to serve as my electronic signature. I understand that my Child Care provider is not permitted to record my child's attendance on my behalf and cannot have access to my personal identification information. I understand that the attendance tracking system may take my photo or a photo of my designee/sponsor as part of the login and logout process. I understand that I am responsible for approving any changes that my provider makes in the attendance tracking system regarding my child's attendance at the program.
- I understand that if my child attends a Step Up To Quality rated program, and if an assessment is completed on my child, the data will be collected and reported to JFS.
- I understand that I must report any changes which affect my Child Care eligibility to my county JFS office, including changes in family income, hours of employment/training/education, family size and address. **I understand that I must report changes within 10 days of the date they occur**.

Signature of Applicant or Authorized Representative	Print Name of Applicant or Authorized Representative	Date

Step 8: If you are applying for child care, please complete the information below

CARETAKER EMPLOYMENT, SCHOOL OR TRAINING *(ATTACH PROOF)*

Caretaker 1 Name and Address of Employer, School or Training Location	Start Date	**Caretaker 2** Name and Address of Employer, School or Training Location	Start Date

CHILDREN WHO NEED CARE

Child 1 Name *(First, Middle, Last)*	Child's Mother's Maiden Name	City of Birth	Is the child entering Kindergarten? ☐ Yes ☐ No If yes, ☐ AM ☐ PM ☐ Full Day	Current Grade Level if the child is in school School year start date: _____ School year end date: _____ Hours of school: from _____ to _____ = _____ (hrs.)
Name and Address of Child Care Provider		Name and Address of Child's School *(if child attends Kindergarten or above)*		
Child 2 Name *(First, Middle, Last)*	Child's Mother's Maiden Name	City of Birth	Is the child entering Kindergarten? ☐ Yes ☐ No If yes, ☐ AM ☐ PM ☐ Full Day	Current Grade Level if the child is in school School year start date: _____ School year end date: _____ Hours of school: from _____ to _____ = _____ (hrs.)
Name and Address of Child Care Provider		Name and Address of Child's School *(if child attends Kindergarten or above)*		

Step 9: Return this form to us. We must receive it by the deadline listed above.

OFFICE USE ONLY- Do not use for medical assistance

Date Received	Caseworker	Caseworker Contact Number

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