

 STATE HEARING REQUEST

*Complete in duplicate.*

Name of Appellant ( <i>Last, Frist, Middle</i> )
Street Address
City, State and Zip Code

Assistance Group Number ( <i>if known</i> ) Or Social Security Number
Program
County

Date of Action Appealed
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Date Notice Issued
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This appeal is in relation to the action (or lack of action) by the \_\_\_\_\_  
I want a hearing because: *(name of local agency)*

Signature	Telephone Number	Date
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We must receive your request for a state hearing with 90 calendar days from the mailing date of the notice of the agency's action. If someone else makes a written hearing request for you, it must include a written statement, signed by you, telling us that person is your representative.  
**Note: The preceding also applies to medical assistance providers. Therefore, hearing requests cannot be accepted from medical providers unless accompanied by the individual's written authorization.**

**Distribution:** Original to the Ohio Department of Job and Family Services, Bureau of State Hearings, P.O. Box 182825, Columbus, Ohio 43218-2825, one copy to local agency.