OSAH FORM 1

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

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:

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*****

This form is available online at http://www.osah.ga.gov or by telephone request at (404) 657-2800.

(OSAH 10/2023)