APPLICATION FOR SNAP, CASH ASSISTANCE, MEDICAL ASSISTANCE OR CHILD CARE

1. 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. Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

2. CHECK THE BOX FOR EACH PROGRAM YOU WANT TO APPLY FOR. If you do not check any boxes, we will only review your eligibility for SNAP.

☐ SNAP	☑ Medical assistance	☐ Child Care Assistance	☐ Cash assistance for families with a minor child(ren) who are at least 6 months pregnant; or for refugees within 8 months of arrival

3. Tell us about you *If you are an Authorized Representative, enter information about the person you are applying for.*

First name	MI	Last name
Simulated	Z	Varga

Do you need any of the following services?

☑ Large Print Notices ☐ Sign language Interpreter

☐ Interpreter ☑ Other: Occupational therapy

What is your preferred language?
Spoken: Turkmen
Written: Spanish

Have you, or anyone living with you, ever received SNAP, cash assistance, medical assistance, or child care assistance?

☐ Yes ☑ No

If yes, who: Alberta Putney

Where (City/County/State): Stamping Ground, Missouri

4. Tell us how to reach you *If you are an Authorized Representative, enter information about the person you are applying for.*

Home Address ☐ Check here if you are homeless. Please give us an address where you can get mail.

7109 Sage Drive

City	County	State	Zip Code
Elkhurst	Greenwood	Arkansas	40331

Phone number	Additional phone number	Email address
(782) 403-4376	(303) 938-5500	varga270@aol.com

Address where you get mail (if different):

4869 6th Street West

City	County	State	Zip Code
Roy	Kent County	Alaska	87077

5. Tell us if you are an Authorized Representative

An Authorized Representative is someone who helps the applicant with the application process. If you are filling out this form as an Authorized Representative, please give us the following information about yourself. Please provide your authorization document with this application. You will not be listed as an Authorized Representative until the document is provided.

First name	MI	Last name
Margaret	J	Tudor

Street address

11730 West 135th Street

City	County	State	Zip Code
Gilgo Beach	Frederick County	Florida	15364

Phone number	Additional phone number	Email address
(611) 374-0919	(521) 616-0907	margaret.tudor@outlook.com

Do you need any of the following services?

☐ Large Print Notices ☑ Sign language Interpreter

☐ Interpreter ☑ Other: Other services representative needs

What is your preferred language?
Spoken: Zhuang
Written: Dhundhari

6. Sign Here

Signature of Applicant or Authorized Representative	Print Name	Date
jerry vasquez	Jerry Vasquez	10/15/2018

DON'T FORGET TO TELL US WHICH PROGRAM(S) YOU ARE APPLYING FOR IN QUESTION 2

7. These questions will help us decide if you can get SNAP quicker.

How many people live with you and buy, fix, and eat meals with you? 4

Answer the following questions only for people live with you and buy, fix, and eat meals with you

Is your total gross income before taxes for the current month less than $150?	☐ Yes	☑ No
Is your total net income after taxes and paying for such things as housing costs, child/dependent care costs, or child support payments for the current month zero?	☐ Yes	☑ No
Are your total resources in cash, checking, and savings accounts less than $100?	☑ Yes	☐ No
Are your monthly rent or mortgage and utilities (such as gas, electric, water, and phone) more than your total monthly gross income before taxes?	☑ Yes	☐ No
Are you a migrant or seasonal farm worker?	☐ Yes	☑ No

8. Tell us about everyone that lives in your home

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, attach a separate piece of paper.

● **Social Security Number**: If you are not a U.S. citizen and are only applying for assistance for U.S. citizens or emergency medical assistance, you do not have to verify your citizenship status, immigration status, or provide a Social Security Number.

● **Sex (gender)**: If your household is only applying for SNAP, you do not have to complete the gender question.

● **U.S. Citizen**: You only have to indicate if someone is a U.S. citizen if they are applying for SNAP, cash assistance or medical assistance, or a child in need of 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, son, Friend, etc)*	**Social Security Number**	**Date of Birth**	**Sex/Gender** *Write M or F*	**U.S. Citizen** *Write Y or N*	**Hispanic or Latino** *Write Y or N*	**Race**
Simulated Varga	self	933-98-1252	11/10/2019	Female	No	Yes	Asian
Tommie	Sibling	204-19-5697	12/16/2018	Male	No	No	Asian
Long Mei	Cousin	568-55-5435	11/25/2018	Female	No	Yes	American Indian or Alaska Native
Nikia Costanza	Aunt	905-43-3756	11/26/2020	Male	Yes	No	Native Hawaiian or Pacific Islander
Elly Pena	Grandparent	963-92-6949	10/11/2021	Male	No	Yes	Native Hawaiian or Pacific Islander
Rachele Pirtle	Caregiver	715-38-4679	11/20/2019	Male	Yes	No	Caucasian
Katia Blom	Sibling	419-24-5358	12/15/2019	Female	No	Yes	Black or African American
Lacy Tilson	Aunt	167-05-7891	11/25/2021	Male	Yes	No	Asian

Are you married? ☐ Yes ☑ No Spouse's name:

Are you, or anyone you are applying for, pregnant? You only need answer if you are applying for cash or medical assistance.
☑ Yes ☐ No If yes, who and what is the due date? Kennith Hinojos 10/18/2016

Do you, or anyone you are applying for, need waiver/long-term care or nursing home care?
☑ Yes ☐ No If yes, who? Marry Smyth

Are you or anyone in your household caring for a disabled person in or outside of the home?
☑ Yes ☐ No If yes, who? Laurence Sanmiguel

Are you or anyone in your household in the military?
☑ Yes (☑ Active Duty ☐National Guard/Reserves) ☐ No

Have you ever been found guilty of child care fraud? ☑ Yes ☐ No

9. Tell us about the people in your home who are 60 years of age or older. *If you do not have anyone this age in your home, you can skip this section.*

Is anyone 60 years of age or older? ☑ Yes ☐ No
If yes, answer the questions in this section. If no, please skip to section 10.

Is this person(s) receiving disability benefits? ☐ Yes ☑ No
If yes, from what source?

Is this person(s) unable to prepare meals due to a disability? ☐ Yes ☑ No

If you answered "yes" to the last three questions, does this person(s) wish to receive SNAP separately from the other people you live with? ☐ Yes ☑ No

10. Tell us about your finances.

Have you or the people in your home received, or expect to receive, income this month? ☐ Yes ☑ No

Income refers to 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.

If yes, please complete the table below.

Name	Type of Income or Name of Employer	How Often Received *(weekly, bi-weekly, etc.)*	Amount of Income *(before taxes)*	Date Last Received
Avis Ling	avis ling sparks Type of income	weekly	422	11/28/2014
Aleisha Ryan	aleisha ryan sparks Type of income	twice a month	569	11/10/2019
Bruna Welty	bruna welty sparks Type of income	monthly	544	11/14/2020

How much do you and the people in your home have in cash, checking, or savings (such as bank accounts, annuities, stocks, or bonds)?
Give your best estimate of the total: 409

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

Did anyone in your home leave a job or lose a job withing the last 60 days? ☑ Yes ☐ No
If yes, who? Kathlene Canter When? 10/27/2017
For what reason? Kathlene Canter Reason

Is anyone in your home on strike from a job? ☐ Yes ☑ No
If yes, who?

11. Which expenses do you and the people in your home pay? Check all that apply. List the amount for each expense.

☑ **Child/dependent care costs**
Estimated amount paid per month: 435

☑ **Child/spousal support payments made to someone outside your home**
Estimated amount paid per month: 555

☑ **Medical expenses for anyone who is disabled or age 60 or over.** These include expenses such as medical bills, prescriptions, health insurance premiums, transportation to medical appointments or other medical services
Estimated amount paid per month: 586

☑ **Rent, mortgage payments, lot rent, property taxes, homeowners' insurance, etc**
Estimated amount paid per month: 547

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

Utilities – Please check the utilities you pay:

☑ Gas
☐ Electricity
☑ Telephone
☑ Garbage
☐ Water
☑ Sewer
☐ Other

12. Tell us about your qualifying activity for child care if you are applying for child care assistance.

If you or the people in your home are working, attending school or participating in a training program, please complete the table below. If employed, please list your current employer. This includes self-employment and odd jobs. **If you need more space, please attach a separate piece of paper.**

Household Member Name	Start Date/End Date	Employer/School/Training Site Name Information	Work or School Schedule *(Please check the box next to the days you work or attend school. Then list the hours you work or attend school on the corresponding line, ie 8:30 - 5:30)*
Avis Ling	11/11/2012 12/20/2016	Name Solimar International Inc	☑ Sun 4:45 am - 2:00 pm ☑ Mon 3:30 am - 4:45 pm
		Address Line 1 1783 Forest Drive	☑ Tues 12:15 am - 1:30 pm ☑ Wed 7:30 am - 11:45 pm
		Address Line 2 Koszta, Iowa 26737	☑ Thurs 11:30 am - 6:30 pm ☑ Fri 5:30 am - 10:30 pm
		Telephone number (553) 376-2663	☑ Sat 1:00 am - 7:00 pm ☑ Varies week to week
Bruna Welty	10/11/2015 12/22/2019	Name Kaiser Associates Inc	☑ Sun 12:45 am - 2:00 pm ☑ Mon 11:45 am - 2:15 pm
		Address Line 1 155 Kapalulu Place	☑ Tues 12:15 am - 1:45 pm ☑ Wed 2:15 am - 7:15 pm
		Address Line 2 East Lempster, New Hampshire 77486	☑ Thurs 8:00 am - 7:15 pm ☑ Fri 5:15 am - 10:30 pm
		Telephone number (129) 954-5370	☑ Sat 3:45 am - 12:00 pm ☐ Varies week to week
Aleisha Ryan	12/25/2016 12/26/2020	Name Neal R Gross And Company Inc	☑ Sun 1:00 am - 6:45 pm ☑ Mon 8:15 am - 9:15 pm
		Address Line 1 8423 Main Street West	☑ Tues 1:15 am - 5:00 pm ☑ Wed 7:45 am - 6:45 pm
		Address Line 2 Central, Alaska 86509	☑ Thurs 2:45 am - 12:15 pm ☑ Fri 1:15 am - 7:30 pm
		Telephone number (141) 174-9099	☑ Sat 12:00 am - 8:00 pm ☑ Varies week to week

13. Tell us more about the child(ren) who need child care

Child 1

Child's name (first, middle, last) Kathaleen Gill		Child's mother's maiden name Bunn
Child's city of birth Chastang	Relationship to applicant Aunt	Child's preferred spoken language Bhojpuri

Is this child a United States citizen or a qualified alien? ☑ Yes ☐ No
You must provide verification in order to receive child care.

Child's Needs
Does child require protective child care? ☑ Yes ☐ No
If yes, is there a case plan? ☐ Yes ☑ No
Is the child enrolled in Head Start? ☐ Yes ☑ No
If yes, what is the child's schedule?
From 8:00 am to 3:00 pm

Days/Hours care needed
☑ Sun From 7:00 am to 3:30 pm
☑ Mon From 7:00 am to 4:00 pm
☑ Tues From 6:30 am to 2:30 pm
☑ Wed From 8:00 am to 12:30 pm
☑ Thurs From 12:00 pm to 6:00 pm
☑ Fri From 8:00 am to 12:30 pm
☑ Sat From 9:00 am to 2:30 pm

Provider Name
Sankofa Freedom Academy Cs

Provider Address
2795 E Bidwell St

City	State	Zip Code
Charlestown	Arkansas	68455

Special needs: Is your child in need of special needs child care based on this definition?
"Special needs child care" means child care provided to a child who is less than eighteen years of age and either has one or more chronic health conditions or does not meet age-appropriate expectations in one or more areas of development, including social, emotional, cognitive, communicative, perceptual, motor, physical, and behavioral development and that may include on a regular basis such services, adaptations, modifications, or adjustments needed to assist in the child's function or development.
☐ Yes ☑ No Please describe:

Child 2

Child's name (first, middle, last)	Child's mother's maiden name	
Mable Giglio	Northcutt	
Child's city of birth	**Relationship to applicant**	**Child's preferred spoken language**
Adna	Grandparent	Amharic

Is this child a United States citizen or a qualified alien? ☐ Yes ☑ No
You must provide verification in order to receive child care.

Child's Needs
Does child require protective child care? ☑ Yes ☐ No
If yes, is there a case plan? ☐ Yes ☑ No
Is the child enrolled in Head Start? ☑ Yes ☐ No
If yes, what is the child's schedule?
From 7:00 am to 2:00 pm

Days/Hours care needed
☑ Sun From 9:00 am to 2:00 pm
☑ Mon From 7:30 am to 2:30 pm
☑ Tues From 6:30 am to 12:00 pm
☑ Wed From 8:30 am to 2:00 pm
☑ Thurs From 8:30 am to 12:30 pm
☑ Fri From 8:00 am to 1:30 pm
☑ Sat From 7:00 am to 2:00 pm

Provider Name
Busy Bees Christian Child Development Center

Provider Address
15418 N. Flowing Wells

City	State	Zip Code
Nottingham	Colorado	14606

Special needs: Is your child in need of special needs child care based on this definition?
"Special needs child care" means child care provided to a child who is less than eighteen years of age and either has one or more chronic health conditions or does not meet age-appropriate expectations in one or more areas of development, including social, emotional, cognitive, communicative, perceptual, motor, physical, and behavioral development and that may include on a regular basis such services, adaptations, modifications, or adjustments needed to assist in the child's function or development.
☐ Yes ☑ No Please describe:

Child 3

Child's name (first, middle, last)	Child's mother's maiden name	
Eryn Montalbano	Turner	
Child's city of birth	**Relationship to applicant**	**Child's preferred spoken language**
Hammon	Cousin	Persian

Is this child a United States citizen or a qualified alien? ☑ Yes ☐ No
You must provide verification in order to receive child care.

Child's Needs
Does child require protective child care? ☐ Yes ☑ No
If yes, is there a case plan? ☐ Yes ☑ No
Is the child enrolled in Head Start? ☑ Yes ☐ No
If yes, what is the child's schedule?
From 6:30 am to

Days/Hours care needed
☑ Sun From 11:00 am to 1:00 pm
☑ Mon From 11:00 am to 2:30 pm
☑ Tues From 10:30 am to 12:00 pm
☑ Wed From 11:00 am to 12:30 pm
☑ Thurs From 10:30 am to 12:30 pm
☑ Fri From 11:00 am to 2:00 pm
☑ Sat From 8:30 am to 1:30 pm

Provider Name
Dinkheller, Sara Dba Dinkheller Daycare

Provider Address
51 Monroe Street

City	State	Zip Code
Weitchpec	Alabama	58962

Special needs: Is your child in need of special needs child care based on this definition?
"Special needs child care" means child care provided to a child who is less than eighteen years of age and either has one or more chronic health conditions or does not meet age-appropriate expectations in one or more areas of development, including social, emotional, cognitive, communicative, perceptual, motor, physical, and behavioral development and that may include on a regular basis such services, adaptations, modifications, or adjustments needed to assist in the child's function or development.
☐ Yes ☑ No Please describe:

Child 4

Child's name (first, middle, last)	Child's mother's maiden name	
Gay Senn	Dufrene	
Child's city of birth Antioch	Relationship to applicant Caregiver	Child's preferred spoken language Malagasy

Is this child a United States citizen or a qualified alien? ☐ Yes ☑ No
You must provide verification in order to receive child care.

Child's Needs
Does child require protective child care? ☑ Yes ☐ No
If yes, is there a case plan? ☑ Yes ☐ No
Is the child enrolled in Head Start? ☐ Yes ☑ No
If yes, what is the child's schedule?
From 6:00 am to 11:30 am

Days/Hours care needed
☑ Sun From 11:00 am to 12:30 pm
☑ Mon From 10:30 am to 1:30 pm
☑ Tues From 12:30 pm to 2:00 pm
☑ Wed From 10:30 am to 12:00 pm
☑ Thurs From 11:00 am to 1:00 pm
☑ Fri From 11:00 am to 12:00 pm
☑ Sat From 12:30 pm to 1:30 pm

Provider Name
Mt. Zion Day Care

Provider Address
5520 Research Park Drive

City	State	Zip Code
Corder	Colorado	67344

Special needs: Is your child in need of special needs child care based on this definition?
"Special needs child care" means child care provided to a child who is less than eighteen years of age and either has one or more chronic health conditions or does not meet age-appropriate expectations in one or more areas of development, including social, emotional, cognitive, communicative, perceptual, motor, physical, and behavioral development and that may include on a regular basis such services, adaptations, modifications, or adjustments needed to assist in the child's function or development.
☐ Yes ☑ No Please describe:

14. Tell us about the school attendance of the child(ren) who need care.

If any child(ren) are attending or will be attending Kindergarten or above, this section must be completed.

Child's name	Current Grade Level	Name and Address of School	Hours of School *(ie 8 am - 3 pm)*	Kindergarten Schedule	School Year Start and End Date
Kathaleen Gill	10th grade	Quarterfield Elementary 17667 Sunset Avenue, Deer Meadows, Washington 94578	10:00 am -4:00 pm	☐ AM ☐ PM ☑ Full Day	11/30/2022 11/24/2023
Mable Giglio	3rd grade	James Mchenry Elementary 18812 S. Boston Ave, Wenatchee, Washington 23690	12:00 pm -12:00 pm	☐ AM ☑ PM ☐ Full Day	12/10/2022 10/15/2023
Eryn Montalbano	11th grade	Laurel Woods Elementary 10404 Homestead Drive, Ririe, Idaho 97620	10:00 am - 12:00 pm	☐ AM ☐ PM ☑ Full Day	12/25/2022 10/12/2023
Gay Senn	6th grade	James Ryder Randall Elementary 18812 S. Boston Ave, Ander, Texas 20571	12:30 pm - 10:00 am	☑ AM ☐ PM ☐ Full Day	10/23/2022 11/24/2023

10. Signature of person who completed this application

By signing this application:

• I understand the questions on this form and certify, under penalty of perjury, that all my answers are correct and complete to the best of my knowledge, including information about the citizenship or alien status of each household member applying for assistance.

• I state under penalty of perjury I have disclosed all annuities and other similar financial devices in which I and/or my spouse have any interest.

• I understand and agree to provide documents to prove what I have said.

• 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.

• I understand that by signing this application and receiving Ohio Works First, I am assigning to the State of Ohio any rights to child/spousal support that is owed to me and/or the minor children in the assistance group during the Ohio Works First eligibility period.

• I understand that by signing this application and receiving Medicaid, I am assigning to the State of Ohio any rights to medical support and any rights to payments by a liable third party for medical assistance owed to me and/or to the minor children in the assistance group during the Medicaid eligibility period.

• I understand that the Ohio Department of Medicaid wll check my answers using information from computer data sources, including the Internal Revenue Service (IRS), the Social Security Administration (SSA), the Department of Homeland Security (DHS), and others. If the information does not match, the Ohio Department of Medicaid may ask me to send more information.

• I understand that the Ohio Department of Medicaid will get information about my financial resources from banks, credit unions, or other financial institutions in order to determine my eligibility lor medical assistance. Authorization to get this information remains in effect until:

o My application lor medical assistance is denied; or

o My eligibility *for* medical assistance ends; or

o I inform the Ohio Department of Medicaid in writing that I wish to end my authorization.

• If I refuse to authorize the Ohio Department of Medicaid to get information about me from financial institutions, or I decide to end my authorization, I understand that my medical assistance may be denied or discontinued.

• I understand that if I am permanently institutionalized or age 55 or older when I receive Medicaid benefits, after my death the Estate Recovery Program will seek to recover payments for the cost of my care paid by Medicaid from my estate. The cost of my care may include the capitation payment that Medicaid pays to my managed care plan, even if the capitation payment is greater than the cost of the services that I actually received.

• I understand that I may be required to cooperate with the child support enforcement agency in establishing paternity or establishing or enforcing a support order. If I am required to cooperate with the child support enforcement agency, a referral will be submitted to the agency on my behalf. I also understand that if I am not required to cooperate with the child support enforcement agency, I may request child support services by completing the JFS 07076 "Application for Child Support Services."

• I understand that in some instances, I may be asked to give consent to the county JFS office to make whatever contacts are necessary to determine my eligibility.

• I understand if I receive cash assistance on the electronic payment card that I must activate my card within 90 days from when benefits and my first card is issued. If the electronic payment card is not activated within 90 days my benefits will be removed from my account.

• I understand that the law provides penalty of fine or imprisonment, or both, for anyone convicted of accepting assistance for which he or she is not eligible.

• By signing and submitting the application, I acknowledge and agree that the county JFS office and ODJFS may share certain details about the status of my application with the child care provider listed in section 13 this application and any amendment thereto, as well as to any child care provider who I authorize to receive information regarding my application.

• I understand that my signature below gives the county JFS office permission to access available information in the Support Enforcement Tracking System (SETS) to verify my child / spousal / medical support income. My signature also gives consent to issue a system generated statewide student identifier (SSID) for each child listed in section 13 of this application.

• My signature below gives my consent and authorizes the county JFS office to access the Ohio Benefits Worker Portal for the purpose of verifying the citizenship status of the children in this case and for verification of the receipt of additional public assistance. I may revoke this authorization at any time by notifying the county JFS office in writing.

• 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 the county JFS office. To remain eligible for publicly funded child care benefits, the required copayment (if applicable) must be paid by me to the provider. Failure to pay the required copayment may result in termination of publicly funded child care benefits.

• I understand that I must report any changes which affect my eligibility to the 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 for child care.

• I understand that if I am approved for child care assistance, 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 may not 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 ODJFS.

• I have received an explanation regarding the requirements for determining child care eligibility, the reasons why I may not be eligible, my right to a state hearing, my responsibility for reporting changes to the 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.

Signature of Applicant or Authorized Representative	If Authorized Representative, Relationship to Applicant	Date
jerry vasquez	neighbor	10/15/2018

16. Return this application to your local County JFS office.

To search for your county office go to http://jfs.ohio.gov/County/County_Directory.pdf

Your civil rights

This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex and in some cases religion or political beliefs. The U.S. Department of Agriculture also prohibits discrimination based on race, color, national origin, sex, religious creed, disability, age, political beliefs or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), 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. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027), found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:
(1) mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410 (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov.
For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish or call the State Information/Hotline Numbers (click the link for a listing of hotline numbers by State); found online at: http://www.fns.usda.gov/snap/contac_info/hotlines.htm. To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS), write: HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (800) 537-7697 (TTY). This institution is an equal opportunity provider.

To file a complaint with the Ohio Department of Job and Family Services (ODJFS) write: ODJFS, Bureau of Civil Rights, 30 E. Broad St., 30th Floor, Columbus, OH 43215 or by fax at (614) 752-6381; or call (614) 644-2703 (voice), (866) 227 -6353 (toll free), or (866) 221 -6700 (TTY).