Ohio Department of Job and Family Services

APPLICATION FOR SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP), CASH ASSISTANCE, MEDICAL ASSISTANCE OR CHILD CARE ASSISTANCE

What if I need help completing this form?

- **If English is not your main language,** ask the County Department of Job and Family Services (county JFS office) to provide someone (an interpreter) who can help you understand the questions on this form.
- **If you are hearing-impaired or visually impaired**, the county JFS office will help you complete this form and the interview.

How do I get assistance?

1. Turn in an application. You can **APPLY ONLINE** at https://ssp.benefits.ohio.gov or fill out this paper application. Submit the paper application to your local county JFS office. To search for your county office, go to http://jfs.ohio.gov/County/County_Directory.pdf .

2. Complete an interview. You will only have an interview if you apply for SNAP or cash benefits. You will get a notice of your interview date and time. There is no interview required to get medical assistance or child care.

3. Provide verifications. Your county JFS office will tell you what verifications they need from you.

PLEASE READ BELOW FOR MORE INFORMATION ON THE APPLICATION PROCESS.

How do I complete this application?

- In Question #2 on the application, check the box to tell us what programs you want to apply for. You can check all of the boxes.
- Answer as many questions on the application as you can. You can fill out just your name, address and signature and turn it in to your local county JFS office. This will start the application process.

If you need SNAP right away, answer the questions in section 7 of the application. You may qualify to get SNAP quicker.

- You have the right to apply for assistance the day you contact your local county JFS office.
- You can choose someone to apply for assistance for you. This person is called an Authorized Representative. You will need to tell us in writing who you want to be your Authorized Representative. If you are an Authorized Representative, answer the questions on this application as they relate to the person you are applying for.
- If any of the information changes after you turn in this application, contact your county JFS office and tell them about the changes.

How do I complete the interview for SNAP or cash assistance? You will not have an interview for medical assistance or child care assistance.

- The county JFS office will give you notice of the date and time of your interview. Your interview will be by telephone. If you want an in-person interview, or you need a home visit to complete your interview, call your county JFS office and tell them.
- Please read your interview notice carefully – it will tell you if you need to call your county JFS office, or if they will call you.
- If you miss your interview, contact your county JFS office as soon as possible. If you do not contact the county JFS office within 30 days from the date you turn in this application, we may deny your assistance and you will have to reapply.
- **For child care only:** if we deny your application, you may be responsible to pay any child care provider who you have used since you turned in your application.

-- Please keep this page for your records. –

What types of verification do I need?

- We will tell you if we need more information. We will send you a notice in the mail. The notice will tell you what you need to turn into your county JFS office. We may ask you for things like paystubs, utility bills, or bank statements. See the chart below. You can submit verifications with this application.
- Be sure to turn in any required information by the date it is due. We may deny your application if you do not turn in all of the information we ask for.
- **If you do not have some of the information we ask for, contact your county JFS office.** We may be able to help you get it or tell you of another way you can get us the information we need.
- 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.

Here are some of the verifications we may need from you:

	Cash Assistance	**SNAP**	**Child Care Assistance**	**Medical Assistance** Families and children	**Medical Assistance** Aged, blind or disabled
Your Social Security Number or proof that you have applied for one.	✓	✓		✓	✓
Permanent Resident Card ("green card") or other immigration documents if not a U.S. citizen	✓	✓		✓	✓
Proof of U.S. citizenship[+]	✓		✓	✓	✓
Proof of income or any other money coming into your household (such as pay stubs, tax records, award letters, child support)	✓	✓	✓	✓	✓
Most recent statements for any bank accounts (such as checking or savings)	✓				✓
Proof of ownership of vehicles (such as a car, truck, motorcycle, boat, or RV)					✓
Proof of current value of stocks/bonds, certificates of deposit, life insurance policies, trusts, annuities	✓				✓
Proof of identity (such as a driver's license, state ID card or passport)	✓	✓			
Proof of any child/dependent care costs	✓	*		✓	
Proof of any child support paid for children not living with you	✓	*	✓	✓	✓
Proof of any housing and utility costs		*			✓
Proof of any medical costs for people with disabilities or for people who are over age 60 (including prescriptions)		*			✓
Proof of any health insurance				✓	✓
Verification of a qualifying activity for all caretakers in the household (such as a school or work schedule, self-sufficiency contract)			✓		
Name and address of an eligible child care provider for each child in need of care.			✓		

[+] When applying for child care assistance, only the citizenship of child needing care is verified.

* Your SNAP amount may increase if you verify these costs.

When will I find out if I am eligible for assistance?

Cash, SNAP, and child care assistance: We will determine your eligibility for these programs within 30 days of the date you turn in your application. If you are eligible, we may approve your benefits back to the date you turned in your application.

Medical assistance: We will determine your eligibility for medical assistance within 45 days of the date you turn in your application. If you are claiming a disability, we may have to conduct a disability determination. This process will take up to 90 days. If you are eligible, we may approve your medical assistance back to the date you turned in your application. If you have medical bills from the 3 months before you applied, tell your county JFS office. You may be able to get medical assistance for those 3 months.

Do I have to be a U.S. citizen to get assistance?

Many non-citizens can receive SNAP, cash assistance, medical assistance and child care assistance. Also, emergency medical assistance may be available without regard to your U.S. citizenship status.

What other services may be available?

You may be eligible to receive other services such as:

- Prevention Retention and Contingency (PRC) services
- early intervention services
- work skills
- help getting a job

These services may require a separate application. Ask your county JFS office about these services.

What is Step Up To Quality?

Step Up To Quality is Ohio's quality-rating system for child care programs. Star ratings are awarded based on the program's implementation of standards that go beyond the minimum health and safety standards. For more information, visit the ODJFS child care website at http://jfs.ohio.gov/cdc/index.stm and click on "Step Up To Quality."

How do I choose a child care provider?

- Caretakers may select any program approved to offer publicly funded child care. These programs include centers, family child care homes, approved day camps, and in-home aides located throughout the state of Ohio.
- If you would like help with selecting a provider, you may contact your local Child Care Resource and Referral Agency. Visit http://jfs.ohio.gov/cdc/families.stm for contact information.
- You may use our Child Care Directory at http://childcaresearch.ohio.gov to look for programs that fit your child care needs. The directory allows you to search by location, type of program, and Step Up To Quality rating. Licensing inspections and substantiated complaints are available for review.

What if my child has a disability or I suspect my child may be developmentally delayed?

For information about additional services for your child, please visit the Ohio Department of Job and Family Services child care website at http://jfs.ohio.gov/CDC/childcare.stm and click on "Families." If you have a child in need of care with a special need that you can verify, you may have more monthly income and still qualify for child care. Ask your county JFS office.

How do I make a complaint about a Child Care Provider?

If you would like to make a complaint about a suspected violation of licensing rules, you may call the Child Care Policy Help Desk at 1-877-302-2347, option 4.

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Reset Form

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) or women who are at least 6 months pregnant; or for refugees within 12 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	Middle Initial

Last Name

Do you need any of the following services?
☐ Large Print Notices ☐ Sign Language Interpreter
☐ Interpreter ☐ Other: _____

What is your preferred language?
Spoken: _____
Written: _____

Have you, or anyone living with you, ever received SNAP, cash assistance, medical assistance, or child care assistance?
☐ Yes ☐ No

If yes, who: _____ Where (City/County/State): _____

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.

City	County	State	Zip Code

Phone Number	Additional Phone Number	E-mail Address
( )	( )	

Address where you get mail (if different):

City	County	State	Zip Code

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	Middle Initial	Last Name

Street Address

City	County	State	Zip Code

Phone Number	Additional Phone Number	E-mail Address
( )	( )	

Does the Authorized Rep need any of the following services?	What is your preferred language?
☐ Large Print Notices ☐ Sign Language Interpreter ☐ Interpreter ☐ Other: _____	Spoken: _____ Written: _____

6. Sign Here

Signature of Applicant or Authorized Representative	Print Name	Date

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? _____

Answer the following questions only for the people who live with you and who 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 the people 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 sex (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
	Self						

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

Are you, or anyone you are applying for, pregnant? You only need to answer if you are applying for cash or medical assistance.

☐ Yes ☐ No If yes, who and what is the due date? _____

Do you, or anyone you are applying for, need waiver/long-term care or nursing home care?

☐ Yes ☐ No If yes, who? _____

Are you or anyone in your household caring for a disabled person in or outside of the home?

☐ Yes ☐ No If yes, who? _____

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

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: $_____

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 within the last 60 days? ☐ Yes ☐ No

If yes, who? _____ When? _____

For what 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: $_____

☐ **Child/spousal support payments made to someone outside your home**
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

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 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)*
		Name Address Line 1 Address Line 2 Telephone No ( )	☐ Sun ______ ☐ Mon ______ ☐ Tues ______ ☐ Wed ______ ☐ Thurs ______ ☐ Fri ______ ☐ Sat ______ ☐ Varies week to week
		Name Address Line 1 Address Line 2 Telephone No ( )	☐ Sun ______ ☐ Mon ______ ☐ Tues ______ ☐ Wed ______ ☐ Thurs ______ ☐ Fri ______ ☐ Sat ______ ☐ Varies week to week
		Name Address Line 1 Address Line 2 Telephone No ( )	☐ Sun ______ ☐ Mon ______ ☐ Tues ______ ☐ Wed ______ ☐ Thurs ______ ☐ Fri ______ ☐ Sat ______ ☐ Varies week to week

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

Child 1

Child's Name *(First, Middle, Last)*

Child's Mother's Maiden Name

Child's City of Birth

Relationship to Applicant

Child's Preferred Spoken Language

Is this child a U.S. 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 __________ to __________

Days/Hours care needed	Provider Name		
☐ Sun From _____ to _____ ☐ Mon From _____ to _____ ☐ Tues From _____ to _____ ☐ Wed From _____ to _____ ☐ Thurs From _____ to _____ ☐ Fri From _____ to _____ ☐ Sat From _____ to _____	Provider Address		
	City	State	Zip Code

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
Child's City of Birth	Relationship to Applicant	Child's Preferred Spoken Language

Is this child a U.S. 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 _____ to _____

Days/Hours care needed	Provider Name		
☐ Sun From _____ to _____ ☐ Mon From _____ to _____ ☐ Tues From _____ to _____ ☐ Wed From _____ to _____ ☐ Thurs From _____ to _____ ☐ Fri From _____ to _____ ☐ Sat From _____ to _____	Provider Address		
	City	State	Zip Code

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

Child's City of Birth

Relationship to Applicant

Child's Preferred Spoken Language

Is this child a U.S. 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 _____ to _____

Days/Hours care needed
☐ Sun From _____ to _____
☐ Mon From _____ to _____
☐ Tues From _____ to _____
☐ Wed From _____ to _____
☐ Thurs From _____ to _____
☐ Fri From _____ to _____
☐ Sat From _____ to _____

Provider Name

Provider Address

City

State

Zip Code

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

Child's City of Birth

Relationship to Applicant

Child's Preferred Spoken Language

Is this child a U.S. 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 _____ to _____

Days/Hours care needed
☐ Sun From _____ to _____
☐ Mon From _____ to _____
☐ Tues From _____ to _____
☐ Wed From _____ to _____
☐ Thurs From _____ to _____
☐ Fri From _____ to _____
☐ Sat From _____ to _____

Provider Name

Provider Address

City

State

Zip Code

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 needs care.

If any child(ren) is 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
				☐ AM ☐ PM ☐ Full Day	
				☐ AM ☐ PM ☐ Full Day	
				☐ AM ☐ PM ☐ Full Day	

15. 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 will 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 for medical assistance. Authorization to get this information remains in effect until:
    - My application for medical assistance is denied; or
    - My eligibility for medical assistance ends; or
    - 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 of 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

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/contact_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).

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Voter Registration and Information Update Form

Please read instructions carefully. Please type or print clearly with blue or black ink.
For further information, you may consult the Secretary of State's website at: VoteOhio.gov or call 877-SOS-OHIO (877-767-6446).

Eligibility

You are qualified to register to vote in Ohio if you meet all the following requirements:

1. You are a citizen of the United States.
2. You will be at least 18 years old on or before the day of the general election.
3. You will be a resident of Ohio for at least 30 days immediately before the election in which you want to vote.
4. You are not incarcerated (in jail or in prison) for a felony conviction.
5. You have not been declared incompetent for voting purposes by a probate court.
6. You have not been permanently disenfranchised for violations of election laws.

Use this form to register to vote or to update your current Ohio registration if you have changed your address or name.

NOTICE: This form must be received or postmarked by the 30th day before an election at which you intend to vote. You will be notified by your county board of elections of the location where you vote. If you do not receive a notice following timely submission of this form, please contact your county board of elections.

Please see information on back of this form to learn how to obtain an absentee ballot.

Numbers 1 and 2 below are required by law. You must answer both of the questions for your registration to be processed.

Identification Requirements

If you have a current Ohio driver's license or state ID card, you must provide that number on line 10. If you do not have an Ohio driver's license or state ID card, you must provide the last four digits of your Social Security number on line 10. If you have neither, please write "None."

Residency Requirements

Your voting residence is the location that you consider to be a permanent, not a temporary, residence. Your voting residence is the place in which your habitation is fixed and to which, whenever you are absent, you intend to return. If you do not have a fixed place of habitation, but you are a consistent or regular inhabitant of a shelter or other location to which you intend to return, you may use that shelter or other location as your residence for purposes of registering to vote. If you have questions about your specific residency circumstances, you may contact your local board of elections for further information.

Your Signature

In the area below the arrow in Box 14, please write your cursive, hand-written signature or make your legal mark, taking care that it does not touch the surrounding lines so when it is digitally imaged by your county board of elections it can effectively be used to identify your signature.

WHOEVER COMMITS ELECTION FALSIFICATION IS GUILTY OF A FELONY OF THE FIFTH DEGREE

I am: ☐ **Registering as an Ohio voter** ☐ **Updating my address** ☐ **Updating my name**

1. Are you a U.S. citizen? ☐ **Yes** ☐ **No**

2. Will you be at least 18 years of age on or before the next general election? ☐ **Yes** ☐ **No**

If you answered NO to either of the questions, do not complete this form.

3. Last Name	First Name	Middle Name or Initial	Jr., II, etc.

4. House Number and Street (Enter new address if changed)	Apt. or Lot #	5. City or Post Office	6. ZIP Code

7. Additional Mailing Address (if necessary)	8. County (where you live)

9. Birthdate (MM/DD/YYYY) (required)	10. Ohio driver's license number, state ID card number, OR last four digits of Social Security number (one form of ID required to be listed or provided)	11. Phone Number (voluntary)

12. **PREVIOUS ADDRESS IF UPDATING CURRENT REGISTRATION** - Previous House Number and Street

Previous City or Post Office	Previous County	Previous State

13. **CHANGE OF NAME ONLY** Former Legal Name	Former Signature

14. I declare under penalty of election falsification I am a citizen of the United States, will have lived in this state for 30 days immediately preceding the next election, and will be at least 18 years of age at the time of the general election.

Your Signature ↓ **Date** (MM/DD/YYYY) _____

FOR BOARD USE ONLY
SEC4010 (rev. 2/7/23)

City, Village, Twp.

Ward

Precinct

School Dist.

Cong. Dist.

Senate Dist.

House Dist.

TO ENSURE YOUR INFORMATION IS RECEIVED, PLEASE DO THE FOLLOWING:

1. Print this form.
2. Make sure all required fields are complete.
3. Sign and date your form.
4. Fold and insert your form into an envelope.
5. Mail your form to your county board of elections.

For your county board's address please visit VoteOhio.gov/Boards

If you have additional questions, please call the office of the Ohio Secretary of State at 877-SOS-OHIO (877-767-6446).

HOW TO OBTAIN AN OHIO ABSENTEE BALLOT

You are entitled to vote by absentee ballot in Ohio without providing a reason. Absentee ballot applications may be obtained from your county board of elections or from the Secretary of State at: VoteOhio.gov or by calling 877-SOS-OHIO (877-767-6446).

OHIO VOTER IDENTIFICATION REQUIREMENTS

Voters must bring photo identification to the polls in order to verify identity. Voters who do not provide identification will still be able to cast a provisional ballot pursuant to R.C. 3505.181. For more information on voter identification requirements, please consult the Secretary of State's website at: VoteOhio.gov or call 877-SOS-OHIO (877-767-6446).

WHOEVER COMMITS ELECTION FALSIFICATION IS GUILTY OF A FELONY OF THE FIFTH DEGREE.