

IN THE \_\_\_\_\_ COURT

COUNTY, OHIO

Applicant Name

Case No(s).

Judge:\_\_\_\_\_

**Application to Seal Record of Conviction  
Pursuant to R.C. 2953.32**

The Applicant moves the Court to order the sealing of the record of conviction in this case and all related records pursuant to R.C. 2953.32.

The Applicant hereby certifies all requirements for sealing the record of conviction are met.

Name of Applicant

Name of Attorney (if applicable)

Signature of Applicant (if pro se)

Signature of Attorney (if applicable)

Street Address of Applicant

Attorney Registration No. (if applicable)

City, State, and Zip Code of Applicant

Street Address of Attorney (if applicable)

Driver's License No. of Applicant (if applicable)

City, State, and Zip Code of Attorney (if applicable)

Telephone of Applicant (if pro se)

Email Address of Attorney (if applicable)

Telephone of Attorney (if applicable)

(TO BE COMPLETED BY THE COURT)

## SERVICE

A copy of this application was served by this Court on the Office of the Prosecutor for \_\_\_\_\_, this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

COURT OF COMMON PLEAS  
LORAIN COUNTY, OHIO  
TOM ORLANDO, CLERK

_____	)	CASE NO. _____
	)	
Plaintiff(s),	)	
v.	)	JUDGE _____
	)	
_____	)	
Defendant(s).	)	AFFIDAVIT OF POVERTY

I, \_\_\_\_\_, a Plaintiff in the within action, hereby state that I am unable to pay the cash security deposit for court costs required by Loc. R. 5(I) for the following reasons (be very specific and attach a separate sheet of paper if necessary):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_.

A "Financial Disclosure Form" is attached hereto in support of this affidavit.

I certify under penalty of the law of perjury that the information provided above is true and accurate to the best of my knowledge. Pursuant to Loc. R. 5(V), I understand that my ability to pay costs is subject to Court review at any stage of the proceedings. I further understand that the Court will ultimately determine which party is responsible for the payment of costs in this action, unless the costs are waived.

\_\_\_\_\_  
SIGNATURE OF FILING PARTY

Sworn to or affirmed by the above named affiant in my presence according to law on this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_ in Lorain County, Ohio.

\_\_\_\_\_  
NOTARY PUBLIC/DEPUTY CLERK OF COURT

# FINANCIAL DISCLOSURE FORM

(\$25.00 application fee may be assessed—see notice on reverse side)

## I. PERSONAL INFORMATION

Applicant's Legal Name		Applicant's Preferred Name and Pronoun		D.O.B.
Mailing Address			City	
State	Zip Code	Case No.	Phone	Cell Phone
SSN Last 4	Gender	Race (double-click to de-select) <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Spanish or Latino <input type="checkbox"/> White <input type="checkbox"/> Other		

## II. OTHER PERSONS LIVING IN HOUSEHOLD

Name	D.O.B.	Relationship	Name	D.O.B.	Relationship
1)			3)		
2)			4)		

## III. PRESUMPTIVE ELIGIBILITY

The appointment of counsel is presumed if the person represented meets any of the qualifications below. Please place an 'X'

Ohio Works First / TANF: \_\_\_\_ SSI: \_\_\_\_ SSD: \_\_\_\_ Medicaid: \_\_\_\_ Poverty Related Veterans' Benefits: \_\_\_\_ Food Stamps: \_\_\_\_

Refugee Settlement Benefits: \_\_\_\_ Incarcerated in state penitentiary: \_\_\_\_ Committed to a Public Mental Health Facility: \_\_\_\_

Other (please describe): \_\_\_\_\_ Juvenile: \_\_\_\_ (if juvenile, please continue at Section VIII)

## IV. INCOME AND EMPLOYER

	Applicant	Spouse (Do not include spouse's income if spouse is alleged victim)	Total Income
Gross Monthly Employment Income	\$	\$	\$
Unemployment, Worker's Compensation, Child Support, Other Types of Income	\$	\$	\$
<b>TOTAL INCOME</b>			\$

Employer's Name: \_\_\_\_\_ Phone Number: (    ) \_\_\_\_\_ - \_\_\_\_\_

Employer's Address: \_\_\_\_\_

## V. LIQUID ASSETS

Type of Asset	Estimated Value
Checking, Savings, Money Market Accounts	\$
Stocks, Bonds, CDs	\$
Other Liquid Assets or Cash on Hand	\$
<b>Total Liquid Assets</b>	\$

## VI. MONTHLY EXPENSES

Type of Expense	Amount	Type of Expense	Amount
Child Support Paid Out	\$	Telephone	\$
Child Care (if working only)	\$	Transportation / Fuel	\$
Insurance (medical, dental, auto, etc.)	\$	Taxes Withheld or Owed	\$
Medical / Dental Expenses or Associated Costs of Caring for Infirm Family Member	\$	Credit Card, Other Loans	\$
Rent / Mortgage	\$	Utilities (Gas, Electric, Water / Sewer, Trash)	\$
Food	\$	Other (Specify)	\$
<b>EXPENSES</b>	\$	<b>EXPENSES</b>	\$

## VII. DETERMINATION OF INDIGENCY

If applicant's Total Income in Section IV is at or below 187.5% of the Federal Poverty Guidelines, counsel must be appointed.

For applicants whose Total Income in Section IV is above 125% of the Federal Poverty Guidelines, see recoupment notice in Section XI.

If applicant's Liquid Assets in Section V exceed figures provided in OAC 120-1-03, appointment of counsel may be denied if applicant can employ counsel using those liquid assets.

If applicant's Total Income falls above 187.5% of Federal Poverty Guidelines, but applicant is financially unable to employ counsel after paying monthly expenses in Section VI, counsel must be appointed.

### VIII. \$25.00 APPLICATION FEE NOTICE

By submitting this Financial Disclosure Form, you will be assessed a non-refundable \$25.00 application fee unless waived or reduced by the court. If assessed, the fee is to be paid to the clerk of courts within 7 days of submitting this form to the entity that will make a determination regarding your indigency. No applicant may be denied counsel based upon failure or inability to pay this fee.

### IX. APPLICANT CERTIFICATION

I, \_\_\_\_\_ (applicant or alleged delinquent child) state:

1. I am financially unable to retain private counsel without substantial hardship to me or my family.
2. I understand that I must inform the public defender or appointed attorney if my financial situation should change before the disposition of the case(s) for which representation is being provided.
3. I understand that if it is determined by the county or the court that legal representation should not have been provided, I may be required to reimburse the county for the costs of representation provided. Any action filed by the county to collect legal fees hereunder must be brought within two years from the last date legal representation was provided.
4. I understand that I am subject to criminal charges for providing false financial information in connection with this application for legal representation, pursuant to Ohio Revised Code sections 120.05 and 2921.13.
5. I hereby certify that the information I have provided on this financial disclosure form is true to the best of my knowledge.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

### X. JUDGE CERTIFICATION

I hereby certify that the above-noted applicant is unable to fill out and/or sign this financial disclosure for the following reason: \_\_\_\_\_. I have determined that the party represented meets the criteria for receiving court-appointed counsel.

\_\_\_\_\_  
Judge's Signature

\_\_\_\_\_  
Date

### XI. NOTICE OF RECOUPMENT

ORC §120.03 allows for county recoupment programs. Any such program may not jeopardize the quality of defense provided or act to deny representation to qualified applicants. No payments, compensation, or in-kind services shall be required from an applicant or client whose income falls below 125% of the federal poverty guidelines. See OAC 120-1-05.

Through recoupment, an applicant or client may be required to pay for **part** of the cost of services rendered, if he or she can reasonably be expected to pay. See ORC §2941.51(D)

### XII. JUVENILE'S PARENTS' INCOME\* – FOR RECOUPMENT PURPOSES ONLY – NOT FOR APPOINTMENT OF COUNSEL

	Custodial Parents' Income (Do not include parents' income if parent or relative is alleged victim)	Total
Employment Income (Gross)	\$ _____	\$ _____
Unemployment, Workers Compensation, Child Support, Other Types of Income	\$ _____	\$ _____
	<b>TOTAL INCOME</b>	\$ _____

\*Please complete Section VI on page 1 of this form if you would like the court to consider your monthly expenses when determining the amount of recoupment which you can reasonably be expected to pay.

**THE FOLLOWING PAGES ARE NOT TO BE FILED WITH THE COURT.**

They will be used by the PSI Department to conduct an investigation pursuant to your request to have your record sealed.

**THE SEALING RECORD QUESTIONNAIRE MUST BE COMPLETED AND  
DELIVERED TO THE ADDRESS LISTED ON THE FOLLOWING  
INSTRUCTION PAGE.**

**THE CLERK'S OFFICE WILL NOT FORWARD THESE DOCUMENTS TO PSI.**

It is your responsibility to deliver them.



**Court of Common Pleas  
Lorain County Adult Probation Department  
Lorain County Courthouse  
308 2<sup>nd</sup> Street  
Phone: (440) 326-4700 / Fax: (440) 326-4735**

In order to better assist the PSI Department in expediting your Sealing of Records, please fill out the attached questionnaire by printing in either blue or black ink.

Please have the questionnaire filled ***out completely and legibly and please return the completed questionnaire within 10 days of applying for your Sealing of Records.***

Once you have filled out the questionnaire — please hand deliver to:

**Lorain County Adult Probation  
PSI Department  
308 Second Street  
Elyria, Ohio 44035  
440-328-2119**

If you are not able to hand deliver — please fax to 440-328-2128 and call 440-328-2119 to set up an appointment.



# LORAIN COUNTY COURT OF COMMON PLEAS

## Lorain County Adult Probation Department

308 Second Street, Elyria, OH 44035  
(440) 326-4700 or 244-6261 Ext. 4700 Fax (440) 328-2128

### Sealing of Records Questionnaire

Name: \_\_\_\_\_ Sex: \_\_\_M\_\_\_F  
Last First Middle  
Alias/Maiden Name: \_\_\_\_\_ U.S. citizen: \_\_\_Yes\_\_\_No

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_ Race: \_\_\_\_\_  
address  
City State Zip Phone #: \_\_\_\_\_

Email: \_\_\_\_\_

Where were you born: \_\_\_\_\_  
City State

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Hair: \_\_\_\_\_ Eyes: \_\_\_\_\_

Have you ever served in the military?: \_\_\_Yes\_\_\_No

Marital Status (Please Circle):

Single Married Divorced Separated Widowed

Number of Children: \_\_\_\_\_

#### Education

Highest Grade Completed: \_\_\_\_\_

#### Fines/Court Costs/Restitution

Paid in Full: \_\_\_Yes\_\_\_No Amount Owed: \_\_\_\_\_

#### Income

Current Income per month: \_\_\_\_\_

Current Employer Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_  
Address City State

**If you are not employed, please indicate one of the following:**

SSI/Disability	Laid Off	Unemployed	Student	Family/Friends Assist

**If you receive government assistance please circle the following that apply and provide an amount that you are awarded per month:**

SSI/SSD Amount: \_\_\_\_\_ Verified (office use only): \_\_\_\_\_

Unemployment Amount: \_\_\_\_\_ Verified (office use only): \_\_\_\_\_

Food Stamps Amount: \_\_\_\_\_ Verified (office use only): \_\_\_\_\_

**Case Number(s) to be sealed:** \_\_\_\_\_

**Criminal Record:**

**Please list all arrests and/or convictions: (If you need additional room please use back)**

[illegible]



**Please provide a statement in regards to your offense or crime. Include any reason you had for committing the crime or offense and how you feel about what you did. (If you need additional room please use back)**

**If you would not like to make a statement please initial here: \_\_\_\_\_**

**Defense Attorney: \_\_\_\_\_**

**Print Name: \_\_\_\_\_**

**Signature: \_\_\_\_\_ Date: \_\_\_\_\_**

**LORAIN COUNTY COURT OF COMMON PLEAS  
ADULT PROBATION DEPARTMENT**

**RELEASE OF INFORMATION**

I, \_\_\_\_\_, hereby grant permission to  
(Name of person releasing information) (Social Security #)

\_\_\_\_\_ to release to the Lorain County  
(Any program to which I am referred and is named above)

Adult Probation Department's attention \_\_\_\_\_, the following information:  
(Probation or Officer of the Court)

1. Drug History 2. Treatment History 3. Current primary drugs of abuse 4. Assessment and treatment recommendations 5. Admission date 6. Type of counseling 7. Counseling attendance 8. Type of medications 9. Medication attendance	10. Urinalysis results 11. Program Violations 12. Goals and general progress 13. Discharge date 14. Discharge Summary 15. Aftercare recommendations 16. Unrestricted oral communications 17. Other, please specify below: Other: _____
18. Research/follow up until probation terminates: (Date of Expiration) _____	

**PURPOSE OR NEED FOR DISCLOSURE:**

- \_\_\_\_\_ **1. Pretrial release supervision and monitoring of release conditions**
- \_\_\_\_\_ **2. Probation Supervision and monitoring of conditions of supervision**
- \_\_\_\_\_ **3. Other, please specify:**

\_\_\_\_\_  
Lorain County Adult Probation Department

I understand that Lorain County Adult Probation Department and programs under its jurisdiction comply with the Health Insurance Portability and Accountability Act of 1997 (HIPAA) as adopted by the Board of Commissioners of Lorain County, Ohio, effective April 11, 2003.

I understand that my participation in a drug treatment and/or mental health treatment program has been made a condition of my pretrial release, intervention in lieu of conviction, suspension of sentence, probation, parole or other (please specify) \_\_\_\_\_. I understand that this consent will expire on the date listed in #18 above. According to 42 CFR Par 2 Section 235 (1987), Federal Confidentiality of Alcohol and Drug Abuse Patient Records, the following are restrictions on redisclosure: "A person who receives patient information under this section may redisclose and use it only to carry out that person's official duties with regard to the patient's conditional release or other action in connection with which the consent was given."

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Person Authorizing Release

RVSD: 6/11