

IN THE _____ COURT
_____ COUNTY, OHIO

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

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
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 1)	D.O.B.	Relationship	Name 3)	D.O.B.	Relationship
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	\$	\$	\$
TOTAL INCOME			\$

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	\$
Total Liquid Assets	\$

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)	\$
EXPENSES	\$	EXPENSES	\$

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	\$ _____	\$ _____
	TOTAL INCOME	\$ _____

*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 2nd 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)

<u>Date</u>	<u>Place</u>	<u>Charge</u>	<u>Result</u>

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	10. Urinalysis results
2. Treatment History	11. Program Violations
3. Current primary drugs of abuse	12. Goals and general progress
4. Assessment and treatment recommendations	13. Discharge date
5. Admission date	14. Discharge Summary
6. Type of counseling	15. Aftercare recommendations
7. Counseling attendance	16. Unrestricted oral communications
8. Type of medications	17. Other, please specify below: <u>Other:</u> _____
9. Medication attendance	

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