

# Hamilton County Juvenile Court

In Re: \_\_\_\_\_

: Case Number \_\_\_\_\_

: **MOTION FOR WAIVER OF DEPOSITS, COSTS  
AND/OR FEES FOR TRANSCRIPT OF  
PROCEEDINGS**

: Case Type (check one)

Dependency  Delinquency  Traffic  Unruly

Now comes \_\_\_\_\_, who hereby requests that the Court determine that they are an indigent litigant and requests a waiver of the deposits, costs and/or fees required for a transcript of proceedings, pursuant to R.C. 2323.311. In support of this Motion, a Civil Fee Waiver Affidavit and Order is attached.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City State Zip Code

## Certificate of Service

I certify that I have served a copy of the foregoing on \_\_\_\_\_

by \_\_\_\_\_ at \_\_\_\_\_.

\_\_\_\_\_  
Signature

**FORM 20. CIVIL FEE WAIVER AFFIDAVIT AND ORDER**

**IN** \_\_\_\_\_

	)	CASE NO.
	)	
Plaintiff,	)	JUDGE
	)	
vs.	)	
	)	<b><u>FINANCIAL DISCLOSURE / FEE-</u></b>
	)	<b><u>WAIVER AFFIDAVIT</u></b>
Defendant,	)	<b><u>AND ORDER</u></b>

Pursuant to R.C. 2323.311, the below-named Applicant requests that the Court determine that the Applicant is an indigent litigant and be granted a waiver of the prepayment of costs or fees in the above captioned matter. The Applicant submits the following information in support of said request.

Personal Information			
Applicant's First Name	Applicant's Last Name		
Applicant's Date of Birth	Last 4 Digits of Applicant's SSN		
Applicant's Address			
Other Persons Living in Your Household			
First Name	Last Name	Is this person a child under 18?	Relationship (Spouse or Child)
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Public Benefits			
I receive the following public benefits and my gross income, including the cash benefits marked below, does not exceed <b>187.5%</b> of the federal poverty guidelines.			
Place an "X" next to any benefits you receive.			
Ohio Works First <sup>1</sup> : <input type="checkbox"/> SSI <sup>2</sup> : <input type="checkbox"/> Medicaid <sup>3</sup> : <input type="checkbox"/> Veterans Pension Benefit <sup>4</sup> : <input type="checkbox"/> SNAP / Food Stamps <sup>5</sup> : <input type="checkbox"/>			

<b>Monthly Income</b>			
I am <b>NOT</b> able to access my spouse's income <input type="checkbox"/>			
	Applicant	Spouse (If Living in Household)	Total Monthly Income
Gross Monthly Employment Income, including Self-Employment Income (Before Taxes)	\$	\$	\$
Unemployment, Worker's Compensation, Spousal Support (If Receiving)	\$	\$	\$
<b>TOTAL MONTHLY INCOME</b>			\$
<b>Liquid Assets</b>			
<b>Type of Asset</b>		<b>Estimated Value</b>	
Cash on Hand		\$	
Available Cash in Checking, Savings, Money Market Accounts		\$	
Stocks, Bonds, CDs		\$	
Other Liquid Assets		\$	
<b>Total Liquid Assets</b>		\$	
<b>Monthly Expenses</b>			
<b>Column A</b>		<b>Column B</b>	
<b>Type of Expense</b>	<b>Amount</b>	<b>Type of Expense</b>	<b>Amount</b>
Rent / Mortgage / Property Tax / Insurance	\$	Insurance (Medical, Dental, Auto, etc.)	\$
Food / Paper Products/Cleaning Products/Toiletries	\$	Child or Spousal Support that You Pay	\$
Utilities (Heat, Gas, Electric, Water / Sewer, Trash)	\$	Medical / Dental Expenses or Associated Costs of Caring for a Sick or Disabled Family Member	\$
Transportation / Gas	\$	Credit Card, Other Loans	\$
Phone	\$	Taxes Withheld or Owed	\$
Child Care	\$	Other (e.g. garnishments)	\$
<b>Total Column A Expenses</b>	\$	<b>Total Column B Expenses</b>	\$
<b>TOTAL MONTHLY EXPENSES (Column A + Column B)</b>			

I, \_\_\_\_\_, hereby certify that the information I have provided on  
 (Print Name)  
 this financial disclosure form is true to the best of my knowledge and that I am unable to prepay the costs or fees in this case.

\_\_\_\_\_  
 Signature

**NOTARY PUBLIC:**

Sworn to before me and signed in my presence this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_,  
 in \_\_\_\_\_ County, Ohio.

\_\_\_\_\_  
 Notary Public (Signature)

\_\_\_\_\_  
 Notary Public (Printed)  
 My Commission expires: \_\_\_\_\_

If available, an individual duly authorized to administer this oath at the Clerk of Court's Office will do so at no cost to the Applicant.

\_\_\_\_\_

## APPENDIX

### 2022 FEDERAL POVERTY LIMIT (FPL)

Persons in family/household	100% Poverty	100% Poverty Monthly Gross Income	187.5% Poverty	187.5% Poverty Monthly Gross Income
1	\$13,590	\$1,132.50	\$25,481.25	<b>\$2,123.44</b>
2	\$18,310	\$1,525.83	\$34,331.25	<b>\$2,860.94</b>
3	\$23,030	\$1,919.17	\$43,181.25	<b>\$3,598.44</b>
4	\$27,750	\$2,312.50	\$52,031.25	<b>\$4,335.94</b>
5	\$32,470	\$2,705.83	\$60,881.25	<b>\$5,073.44</b>
6	\$37,190	\$3,099.17	\$69,731.25	<b>\$5,810.94</b>
7	\$41,910	\$3,492.50	\$78,581.25	<b>\$6,548.44</b>
8	\$46,630	\$3,885.83	\$87,431.25	<b>\$7,285.94</b>

R.C. 2323.311(B)

(4) A judge or magistrate of the court shall review the affidavit of indigency as filed pursuant to division (B)(2) of this section and shall approve or deny the applicant's application to qualify as an indigent litigant. The judge or magistrate shall approve the application if the applicant's gross income does not exceed one hundred eighty-seven and five-tenths per cent of the federal poverty guidelines as determined by the United States department of health and human services for the state of Ohio and the applicant's monthly expenses are equal to or in excess of the applicant's liquid assets as specified in division (C)(2) of section 120-1-03 of the Administrative Code, as amended, or a substantially similar provision. If the application is approved, the clerk shall waive the advance deposit or security and the court shall proceed with the civil action or proceeding. If the application is denied, the clerk shall retain the filing of the action or proceeding, and the court shall issue an order granting the applicant whose application is denied thirty days to make the required advance deposit or security, prior to any dismissal or other action on the filing of the civil action or proceeding.

(6) Nothing in this section shall prevent a court from approving or affirming an application to qualify as an indigent litigant for an applicant whose gross income exceeds one hundred eighty-seven and five-tenths per cent of the federal poverty guidelines as determined by the United States department of health and human services for the state of Ohio, or whose liquid assets equal or exceed the applicant's monthly expenses as specified in division (C)(2) of section 120-1-03 of the Administrative Code, as amended, or a substantially similar provision.

---

<sup>1</sup>Ohio Works First Income Limit: 50% FPL (R.C. 5107.10(D)(1)(a))

<sup>2</sup>SSI Income Limit: cannot have countable income that exceeds the Federal Benefit Rate (FBR). 2019 FBR: \$771 monthly for single disabled individual; \$1157 monthly for disabled couple (20 CFR 416.1100)

<sup>3</sup>Medicaid Income Limit:

Modified Adjusted Gross Income (MAGI):138% FPL (OAC 5160:1-4-01; 42 USC 1396a(a)(10)(A)(i)(VIII))

Aged, Blind or Disabled: \$791 for single person; \$1177 for disabled couple

<sup>4</sup>Veterans Pension Benefit Income Limit: \$13,535 annually / \$1,127 monthly for a single person; \$17,724 annually / \$1,477 monthly for a veteran with one dependent

<sup>5</sup>Supplemental Nutrition Assistance Program (SNAP) Income Limit: 130% FPL for assistance groups with nondisabled/nonelderly member; 165% FPL for elderly and disabled assistance groups (OAC 5101:4-4-11; Food Assistance Change Transmittal No. 61)