

# WITHDRAWAL OR STOP BENEFITS/APPEAL REQUEST

Please PRINT all information

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

1. I wish to **WITHDRAW MY APPLICATION/STOP BENEFITS** for the programs checked below:

- AHCCCS Health Insurance      Nutritional Assistance      Tuberculosis Control
- Cash Assistance/Two-Parent Employment Program (TPEP)

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I want benefits **STOPPED** for:

NAME	DATE OF BIRTH	RELATIONSHIP TO YOU

If you are working, you and your family may still be eligible for AHCCCS Health Insurance and/or Nutrition Assistance benefits. Please talk to your worker before withdrawing your application or stopping your benefits.

Please check the reason for **WITHDRAW APPLICATION/STOP BENEFITS**:

- Employment (Name) \_\_\_\_\_ started working on (Date) \_\_\_\_\_  
and earns (Amount) \_\_\_\_\_ per (Hour/Day/Week) \_\_\_\_\_  
at (Employer's Name and Phone Number) \_\_\_\_\_
- Moving out of state (State moving to) \_\_\_\_\_ Date of move: \_\_\_\_\_
- How long will you be out of state: \_\_\_\_\_
- Other: \_\_\_\_\_

2. I wish to **WITHDRAW** my request for an **APPEAL** for the following programs:

- AHCCCS Health Insurance      Nutrition Assistance      Tuberculosis Control
- Cash Assistance/Two-Parent Employment Program (TPEP)

**I understand that if I received Cash Assistance and/or Nutrition Assistance benefits while waiting for an appeal, I may have to repay the benefits received that I was not eligible for. I understand that if I asked for an appeal due to an overpayment, and I withdraw my appeal request I will have to pay the overpayment back.**

The reason I am WITHDRAWING my request for an APPEAL is: \_\_\_\_\_

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## AGENCY USE ONLY

Date verbal withdrawal received: \_\_\_\_\_ Worker's D0 Number: \_\_\_\_\_

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