FAA-0574A FORFF (7-19)

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Family Assistance Administration

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: _____