

**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)**

**See pages 5-6 for USDA/EOE/
ADA/LEP/GINA disclosures**

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 a APPEAL is:

Name: _____

Signature: _____

Date: _____

AGENCY USE ONLY

**Date verbal
withdrawal received:** _____

Worker's D0 Number: _____

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programs, services, activities, or employment based on race, color, religion, sex, national origin, age, disability, genetics and retaliation. To request this document in alternative format or for further information about this policy, contact your local office; TTY/TDD Services: 7-1-1. • Free language assistance for DES services is available upon request. • Disponible en español en línea o en la oficina local.