ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Family Assistance Administration

WITHDRAWAL OR STOP BENEFITS/APPEAL REQUEST

Please PRINT all information

Case Name:

Case Number:

See pages 9-11 for USDA/EOE/ ADA/LEP/GINA disclosures

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 a APPEAL is:

_____

_____

Name: _____

Signature: _____

Date: _____

AGENCY USE ONLY

Date verbal withdrawal received: _____

Worker's D0 Number:

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