

**ARIZONA DEPARTMENT OF
ECONOMIC SECURITY
Family Assistance Administration
CASH ASSISTANCE BENEFIT
LIMIT EXTENSION REQUEST**

To request an extension of Cash Assistance (CA), please complete the information below.

Proof to support your extension reason may be required.

I would like to request an extension of CA for the following reason:

A hardship prevents us from supporting the dependent children in our family without CA.

Name of adult family member in need of hardship extension:

Is a non-parent, age 60 or older, and provides the sole care for all dependent children in my case receiving CA.

See page 5 for USDA/EOE/ADA disclosures

Is temporarily or permanently disabled (*e.g., receiving ongoing mental or physical medical treatment that prevents me from working*).

Is a caregiver for a child, parent, spouse or domestic partner with a disability.

Is a victim of domestic violence, a crime, or any other violence.

Is homeless.

Is unable to finish current education or training program without CA.

Is unable to find or afford the child care.

Is unable to find available or affordable transportation to work in my area.

Has another hardship reason that I feel keeps me from becoming self-sufficient (*explain*).

We are requesting a CA Time Limit extension for an additional 12 months of CA benefits. I certify we meet both of the following requirements:

All children, ages 6-15, in your household are required to attend school and meet the school attendance requirements, unless one of the following applies:

- a. The child has excused absences.**
- b. The child is enrolled in a vocational, technical, career or educational training program approved by the Department of Education.**
- c. The school has excused the child from attending the school because of physical or**

mental condition or because of suspension or expulsion.

No one in our budgetary unit had a Jobs sanction during our final month of CA benefits and the final month was October 2017 or later.

I have provided copies of the following information to verify my extension request reason:

Name (*Last, First, M.I.*) (*Print or type*)

Signature _____

Date _____

This institution is an equal opportunity provider

- **DES/TANF Agencies are Equal Opportunity Employers/Programs**
- **Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI & VII), and the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Title II of the Genetic Information Nondiscrimination Act (GINA) of 2008; the Department prohibits discrimination in admissions, 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.**