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 5-8 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: _____

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities

who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at https://www.usda.gov/sites/default/files/documents/ad-3027.pdf, from any USDA office, by calling (833) 620-1071, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and

a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to:

1. mail:

Food and Nutrition Service, USDA

1320 Braddock Place, Room 334

Alexandria, VA 22314; or

2. fax:

(833) 256-1665 or (202) 690-7442; or

3. email:

FNSCIVILRIGHTSCOMPLAINTS@usda.gov

This institution is an equal opportunity provider.

To request this document in alternative format or for further information about

this policy, contact your local office; TTY/TDD Services: 7-1-1.