State of Alaska
Department of Health & Social Services
Division of Public Assistance

ATAP Extension Review Form

Case Name: _____ Case Number: _____
Name of Additional Parent in the Case (if any): _____
Date of Extension Review: _____

PART A – EXTENSION RECOMMENDATION: 60 Month Time Limit Extension Criteria

1. Does it appear that the family fits the criteria for an extension to Temporary Assistance? ☐ Yes ☐ No
   If yes, select all extension criteria reasons that apply and explain why. If there is more than one parent in the case, list the parent's name with each reason that applies to that individual. The reasons selected should be severe enough on their own or in conjunction with co-occurring conditions to allow an extension.

☐ Domestic violence (DV) _____

☐ Incapacity (IC) _____

☐ Caring for a disabled child (DC) _____

☐ Hardship – Caring for a disabled relative (DR) _____

☐ Hardship – Disaster (DS) _____

☐ Hardship – Children at risk of placement outside of home (CR) _____

☐ Hardship – Learning disability (LD) _____

☐ Hardship – Limited English proficiency (LE) _____

☐ Hardship – Substance abuse treatment (SA) _____

☐ Hardship – Physical health (PH) _____

☐ Hardship – Mental health (MH) _____

☐ Hardship – Other limitations on employment (EM) _____

2. If the family ***does not*** appear to fit criteria for an extension, document any criteria that were considered and why is was not applicable for allowing an extension.

PART B – CLIENT REQUEST FOR EXTENSION

☐ I am **NOT** requesting an extension to my 60 month time limit on Temporary Assistance.

☐ I am requesting an extension to my 60 month time limit on Temporary Assistance for the following reason:

Print Name _____ Signature _____ Date _____

If client is not present and the request is completed by telephone, list the date contacted. _____
If request is completed by mail, list the date the notice was sent to the client asking if they want to request an extension. _____ List the date of response. _____

PART C – EXTENSION DECISION

Extension: _____ Allowed Number of Months: _____ Extension Start Date: _____ End Date: _____
_____ Denied

Comments: _____

Case Manager Name (Print) _____ Signature _____ Date _____

Original form is kept in the case management file and a copy is kept in the eligibility file.

If an Extension Review staffing is held, attach this form to the front of the ATAP Case File Summary & Recommendations form packet.