



## 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) \_\_\_\_\_  
\_\_\_\_\_



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☐ 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:

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Date

## **PART C – EXTENSION DECISION**

Comments: \_\_\_\_\_

Date

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