



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

Dear _____,

You have received your 60-month lifetime limit on Temporary Assistance. You may be able to receive more assistance if you are not able to work because of problems with domestic violence, a medical condition, you are providing care for a child with a disability, or have other problems.

In order to process your application for Temporary Assistance, I need more information from you. Please complete the information below and return it to me by _____.

Sincerely,

APPLICANT REQUEST FOR MORE MONTHS ON
TEMPORARY ASSISTANCE

Do you want to be considered for more months on Temporary Assistance?

Yes _____

No _____

If yes, please explain why you need more months of Temporary Assistance.

I need more time on Temporary Assistance because:

Name (please print)

Social Security Number

Signature

Date