



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,

\_\_\_\_\_

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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