



## 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**

Does it appear that the family fits the criteria for an extension to Temporary Assistance?

Yes \_\_\_\_\_ No \_\_\_\_\_

*If yes, please indicate the extension criteria that are applicable and why. If there is more than one parent in the case, please list the name of the parent with each reason that applies to that individual. (Select as many reasons as are applicable. 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) \_\_\_\_\_  
\_\_\_\_\_

