JOE LOMBARDO
Governor

STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF WELFARE AND SUPPORTIVE SERVICES

RICHARD WHITLEY, MS
Director

ROBERT THOMPSON
Administrator

☐ TANF ☐ MEDICAID ☐ SNAP

Date: _____
Case Name: _____
Case ID: _____

VOLUNTARY REDUCTION, WITHDRAWAL OR TERMINATION OF ASSISTANCE

I request my assistance/application from the following program(s) be _____ effective _____
(terminated, withdrawn, reduced) (month/day/year)

☐ Temporary Assistance for Needy Families (TANF)
☐ Family Medical (FMC)
☐ Supplemental Nutrition Assistance Program (SNAP)
☐ Medical Assistance to the Aged, Blind and Disabled (MAABD)

Reason:

I waive my right to the required advance Notice of Adverse Action Period and the continuance of benefits should a hearing on this action be requested at a later date.

This request is made voluntarily, free from threats or promises of any kind.

Client Signature	Print Name	Date	Telephone Number
		/ /	

Case Manager Signature	Print Name	Date	Telephone Number