



STEVE SISOLAK  
Governor

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

RICHARD WHITLEY, MS  
Director

STEVE H. FISHER  
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effective \_\_\_\_\_ (month/day/year) (terminated, withdrawn, reduced)

- 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
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Case Manager Signature	Print Name	Date	Telephone Number
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