Case Closure Request
Department of Social Services
Division of Family Independence| TA, CED
B-5502 (10/2018)

Client Name		Date
Case Number		CIN/SSN
Address	City	Zip Code

I the undersigned, request that my Temporary Assistance case be closed effective: _____

I wish to continue assistance for those checked below:

- ☐ Supplemental Nutrition Assistance Program
- ☐ Medical Assistance
- ☐ Other: _____
- ☐ Other: _____

Client Signature			Date	
TA Worker Name	Phone Number	Office	Unit #	Worker #
Employment Counselor			Phone Number	
Close case – Code M-94 (Written request TA Only)				