pennsylvania
DEPARTMENT OF PUBLIC WELFARE
www.dpw.state.pa.us

DISCONTINUANCE AUTHORIZATION

CASE IDENTIFICATION				
CO	RECORD NUMBER	CAT	CTR-DIG	DIST

NAME
ADDRESS

I/we agree that the State assistance granted to me/us is for the period until I receive Supplemental Security Income (SSI) for which I/we have applied or am applying. I understand that the PENNSYLVANIA DEPARTMENT OF PUBLIC WELFARE upon receipt of my/our initial payment will terminate State assistance payments 10 days after receipt of the SSI payment or for the next assistance payment date, whichever is later.

I/we further understand that receipt of my/our SSI award letter acts as a notice that State assistance will be discontinued as described above. Any appeal from discontinuance of my/our State assistance must be filed within 15 days from receipt of the SSI award letter.

Witness	Signature	Date
Witness	Signature	Date

CLIENT

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CASE FILE