

## Massachusetts Department of Transitional Assistance

## Request for Adjustment of the 24-Month Time Limit

		Date		
Recipient Name		Agency ID:		
I request an adjustment of my 24-Month	Time Limit for the following	g month(s)		
MM/YY	MM/YY	MM/YY		
because:				
Recipient's Signature			Date	
Department Representative's Signature			Date	
Supervisor's Signature			Date	