RESET

CAO NAME AND ADDRESS

Pennsylvania
Department of Human Services

CASE IDENTIFICATION				
CO	RECORD NUMBER	CAT	CSLD	DIST
RECORD NAME				DATE

SNAP Medical Exemption Form

Dear Medical Provider or School Official:

For some students and certain other adults, eligibility for Supplemental Nutrition Assistance Program (SNAP) benefits may be restricted or time-limited. Individuals can be exempt from this requirement if they are medically certified as physically or mentally unfit for employment. Please help us determine whether your patient or student meets an exemption due to a physical or mental condition that limits their ability to work.

Patient/Student name: _____ Date of birth: _____

Patient/Student authorization:
I hereby authorize the release of the medical, rehabilitation participation, and/or reasonable accommodation information requested to the Pennsylvania Department of Human Services.

Signature: _____ Date: _____ /_____ /_____

Please answer the relevant questions below. Once completed, sign and date this form including your title or position in your agency.

Questions 1 and 2 may be completed by a physician, physician's assistant, designated representative of the physician's office, nurse practitioner, osteopath, psychologist, drug and alcohol abuse counselor, mental health counselor, social worker, midwife, podiatrist, audiologist, physical therapist, occupational therapist, optometrist, or any other medical personnel whose services may be reimbursed by Medical Assistance.

Question 3 may be completed by any medical provider listed above or by a school official familiar with the services the individual is receiving. **Only complete Question 3 if the individual is enrolled in school half-time or more.**

1. Does this individual have a mental or physical condition or illness that reduces their ability to work?
   (NOTE: The condition may be either temporary or permanent and does not need to meet the Social Security standard to qualify. For students, consider the individual's ability to work <u>while also</u> attending school.)

   ☐ Yes ☐ No If **yes**, specify condition: _____

2. Is this individual participating in a drug/alcohol treatment or counseling program, mental health counseling program, or a vocational rehabilitation program?

   ☐ Yes ☐ No If **yes**, specify program: _____

   If **ongoing**, specify date program will end: _____ /_____ /_____

3. Does this individual currently receive reasonable accommodations or other assistance from a postsecondary institution's disability access or reasonable accommodations office?

   ☐ Yes ☐ No If **yes**, specify condition: _____

By signing, I certify that all information provided above is true and accurate.

_____ _____
Name (please print) Title/profession

_____ _____ /_____ /_____
Signature Date form signed

_____
Address and phone number