

Dear Medical Provider:

The Supplemental Nutrition Assistance Program (SNAP, formerly the Food Stamp program), limits Able-Bodied Adults without Dependents (ABAWD) to only 3 months of SNAP within 36 months. This rule applies unless the adult is working a minimum of 20 hours per week or is exempt from the time limit because the individual is medically certified as physically or mentally unfit for employment or falls within another exemption. Please help us determine whether your patient meets the exemption due to medical or mental issues and can be exempted from the ABAWD provisions.

Patient's name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

**Patient/participant's authorization:**

I hereby authorize the release of the medical information and/or rehabilitation participation requested to the Pennsylvania Department of Human Services.

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Please answer one or more of the following questions in the box below. Please sign and date this form including your title or position in your agency\*.

1. Is this individual pregnant?

Yes  No If **yes**, due date? \_\_\_\_/\_\_\_\_/\_\_\_\_

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

Yes  No If **yes**, specify program: \_\_\_\_\_

Is this program ongoing?  Yes  No If **no**, date program will end: \_\_\_\_/\_\_\_\_/\_\_\_\_

3. Does this patient have a **mental and/or physical illness or disability** which reduces his or her ability to financially support him or herself?

Yes  No If **yes**, specify disability: \_\_\_\_\_

Is this condition ongoing?  Yes  No If **no**, date it is expected to end: \_\_\_\_/\_\_\_\_/\_\_\_\_

I certify that the information provided above is true and accurate.

\_\_\_\_\_  
Name (please print)

\_\_\_\_\_  
Title/profession\*

\_\_\_\_\_  
Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date form signed

\_\_\_\_\_  
Address and phone number

\* This form may be signed by any of the following: 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.