State of Illinois
Department of Human Services

SNAP WORK REQUIREMENT REQUEST - MEDICAL-SERVICE PROVIDER UNFIT TO WORK DETERMINATION

Medical - Service Provider:

Please help us determine if the person named below is mentally or physically fit for employment. Please answer the questions in the appropriate section of this form for your profession and sign in the signature section. You do not need to provide medical records. We must have this form returned to us by _____ to determine this person's eligibility for benefits.

This information will help us determine if your patient is unfit to participate in work requirements, per Section 6(o) of the Food and Nutrition Act of 2008. This form is voluntary.

To be completed by SNAP Recipient:

I, (please print name) _____ ,

living at (please print address) _____ ,

request verification of my:

- ☐ physical or mental condition
- ☐ participation in a drug and alcohol program
- ☐ participation in homelessness services
- ☐ participation in domestic violence services

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

Signature: _____ Date: _____

To be completed by Healthcare Professional**

Does this person have a temporary or permanent mental and/or physical condition which restricts his or her ability to:

- Work at a job 20 hours per week? Yes ☐ No ☐
- Participate in a work and training program activity for 80 hours per month? Yes ☐ No ☐

If yes, please indicate the duration of the patient's inability due to this illness/disability.

- ☐ less than 30 days
- ☐ 1-3 months
- ☐ 3-6 months
- ☐ 6-9 months
- ☐ 9-12 months
- ☐ more than 12 months, or indefinite

Is this person pregnant? Yes ☐ No ☐

To be completed by Staff/Social Worker at a Drug and Alcohol Treatment Program**

Is this person a participant in a drug and alcohol treatment or counseling program?

If yes, what is the start date of the program: _____

When will the program end? _____

To be completed by Staff/Social Worker at a Homelessness Services Provider or Shelter**

Is this person experiencing homelessness and have a reduced ability to:

- Work at a job 20 hours per week? Yes ☐ No ☐
- Participate in a work and training program activity for 80 hours per month? Yes ☐ No ☐

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To be completed by Staff/Social Worker at a Domestic Violence Services Provider or Shelter**

Is this person a survivor of domestic violence and have a reduced ability to:

- Work at a job 20 hours per week? Yes ☐ No ☐
- Participate in a work and training program activity for 80 hours per month? Yes ☐ No ☐

REQUIRED
SIGNATURE AND CONTACT INFORMATION

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

Name (please print) _____ Signature _____

Title/Profession** _____ Date (MM/DD/YY) ☐☐ / ☐☐ / ☐☐ Phone _____

Address: _____