State of Illinois
Department of Human Services

4 (Permanent)

SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)
WORK REQUIREMENT - COMMUNITY WORKFARE VERIFICATION

Date: _____

Case Number: _____

Office Name: _____

Office Address: _____

_____

Case Name: _____

Address: _____

Address: _____

City/State/Zip: _____

Phone: _____

TTY: _____

Fax: _____

To certifying agency: In order to meet SNAP eligibility requirements, _____ must perform community workfare for a local organization. The number of hours the person must work is dependent on the amount of SNAP benefits they receive. See below. We ask that you complete and sign the statement below to verify the number of hours worked. Thank you for your assistance. **The person named above is responsible for returning this form to the correct DHS office.**

This form is authorized by 89 Ill. Adm. Code 121.160 and is voluntary. There are no penalties to your agency for failure to respond.

However, ongoing eligibility for SNAP benefits for _____ may be affected if this form is not completed and returned in a timely manner.

I certify that _____ performed community workfare during the month of _____

for _____ hour(s).

It is expected that this individual will: ☐ continue to work the required number of hours each month.

☐ work the required number of hours through the month of _____ .

Agency Name: _____

Address: _____

Telephone: _____

Printed Name: _____ Title: _____

Signature: _____ Date: _____

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To the SNAP household: The number of hours you must work is determined by dividing your household's total SNAP benefit amount by the State minimum wage of $13.00 hourly. For example, if you are a single person SNAP household and are receiving the maximum amount of SNAP $281, you will need to perform community workfare for an average of 20 hours monthly = ($281 ÷ $13.00) round down.
The number of hours worked is a household obligation. For SNAP households with more than one person, you may choose that only one member will meet the obligation or that the obligation will be split between the non-exempt members.

Your SNAP household required monthly work hours is calculated below.

This section to be completed by FCRC staff only.

Monthly SNAP Benefit Amount	÷	(State Minimum Wage)	=	Your Required Work Hours
	÷	$13.00	=	0

The person(s) named below will perform the work hours. Check the appropriate box.

☐ The total required monthly work hours will be met by: _____.
Name of Person

☐ Each individual listed below has agreed to perform a portion of the work hours to meet the total required monthly work hours.

Name of Person	Number of Agreed Hours

I understand that it is my responsibility to report when I am no longer meeting this requirement **within 10 calendar days of the date I learn of the change.**

Customer Printed Name: _____

Customer Signature: _____ Date: _____

FCRC Staff Printed Name: _____

FCRC Staff Signature: _____ Date: _____