State of Illinois
Department of Human Services

4 (Permanent)

SNAP (SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM) WORK REQUIREMENT - (NON-SNAP E&T COUNTIES) COMMUNITY WORK VERIFICATION

Date: ____________________

Case Number: ____________________

Office Name: ____________________

Office Address: ____________________

____

Phone: ____________________

TTY: ____________________

Fax: ____________________

Case Name: ____________________
Address: ____________________
Address ____________________
City/State/Zip: ____________________

To certifying agency: In order to meet SNAP eligibility requirements, ____________________ must perform community work for a local organization. The number of hours the person must work is 20 hours per week. We ask that you complete and sign the statement below to verify on a monthly basis 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 work during the month of ____________________

for ____________ hour(s).

Agency Name: ____________________

Address: ____________________

Telephone: ____________________

Printed Name: ____________________ Title: ____________________

Signature: ____________________ Date: ____________________