State of Illinois
Department of Human Services

SNAP EMPLOYMENT AND TRAINING CHANGE REPORT FORM

Customer Information:

Case Name: ______________________ Referral Date: ______________
Participants Name: ______________________ Case Number: ______________
Address: ______________________ Phone: ______________
City, State, Zip: ______________________ Email Address: ______________

FCRC Information:

Office Name: ______________________ Phone Number: ______________
Address: ______________________ Fax: ______________
City, State, Zip: ______________________ TTY: ______________

Provider Information:

Name: ______________________ Phone Number: ______________
Address: ______________________ Fax: ______________
City, State, Zip: ______________________ TTY: ______________
Appointment Date/Time: ______________________ Show ☐ No Show ☐

SNAP Employment and Training Activity
Must be one of the following:
Vocational Training, Basic Education, ESL, Community Workfare, Supervised Job Search, Job Search Training, Work Readiness Training, Internship, On-the-Job Training, and Transitional Jobs/Earnfare.

Activity: ____________ Hours: ____________ Start Time: ____________ End Time: ____________
Activity: ____________ Hours: ____________ Start Time: ____________ End Time: ____________
Activity: ____________ Hours: ____________ Start Time: ____________ End Time: ____________
Activity: ____________ Hours: ____________ Start Time: ____________ End Time: ____________

Client went to work:

Employer Name: ____________ Contact Name: ____________ Phone: ____________
Address: ____________ City: ____________ State: ____________ Zip: ____________
Job Title: ____________ Start Date: ____________ First Pay Date: ____________
Wages per Hour: ____________ Hours per week: ____________
Initial Employment Expenses Issued: Yes ☐ No ☐

Case Comments:

____
____
____

____ ____________
FCRC Printed Name and Signature Date

State of Illinois
Department of Human Services

SNAP EMPLOYMENT AND TRAINING CHANGE REPORT FORM

Case Number: ______________________________

Name of Client: (printed) Last: ____________________ First: ____________________ Middle: ____________________

Date of Birth: ____________________ ☐ Male ☐ Female
(Month) (Day) (Year)

By signing below, you agree that you have read and agree to the following. If you do not understand something or have questions, be sure to ask. I hereby authorize the DEPARTMENT OF HUMAN SERVICES to disclose the following information about me for the purpose of providing me with service coordination.

Information to be disclosed (date, type of services including treatment recommendations, compliance status, schedule of activities, ability to engage in work activities, work schedule, supportive service needs, and justification):

☐ ______________________________ Client Initials: __________
(Information to be Disclosed)

The above checked information is to be disclosed to ______________________________ only as necessary in order to administer the service coordination or for audit and evaluation purposes.

I hereby authorize (Service Provider Organization Name) ______________________________
to disclose the following information about me for the purpose of providing me with service coordination.
Information to be disclosed (date, type of services including treatment recommendations, compliance status, schedule of activities, ability to engage in work activities, work schedule, supportive services, needs, and justification):

☐ ______________________________ Client Initials: __________
(Information to be Disclosed)

The above checked information is to be disclosed to the DEPARTMENT OF HUMAN SERVICES, only as necessary in order to administer the service coordination or for audit and evaluation purpose.

I understand that I may revoke this consent at any time in writing, but that revoking it will not cancel what was already done before I revoked it. I understand that I have the right to inspect and copy the information to be disclosed. If not previously revoked, this consent will terminate upon the completion of the service coordination, but in no event shall exceed one year from today. It has been explained to me that if I refuse to consent to this disclosure or if I revoke my consent during the case coordination, I may not receive case coordination services and my public assistance benefits may be affected. I understand that I may, however, receive mental health services and substance abuse treatment services, without agreeing to this consent.

☐ Check here if client refuses to sign consent.

Signature of Client: ______________________________ Date: ____________

Signature of Parent, Guardian, or
Authorized Representative (if appropriate): ______________________________ Date: ____________

Signature of Witness: ______________________________ Date: ____________

NOTICE TO RECEIVING PERSON: The information released hereunder may not be re-disclosed except as set forth herein or as otherwise allowed by law. If the information pertains to substance abuse services, it has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The federal rules prohibit further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or persecute any alcohol or drug abuse patient. Violation of the federal rules is a criminal offense.