Kondisyon Travay Ap Vini Pou Anpil Moun Ak SNAP.

Aji pou Kenbe Benefis Ou yo!

Koumanse depi 1 Septanm 2025, anpil adilt pral bezwen travay 20 èdtan pa semèn pou yo sa kenbe SNAP yo a. Règ travay sa yo pa aplike pou moun ki gen egzansyon. Si ou pa gen egzansyon oswa ou pa travay 20 èdtan pa semèn, ou ka sèlman gen 3 mwa SNAP nan 3 lane.

Ou PA bezwen ranpli kondisyon travay SNAP yo si:

- Ou gen yon kondisyon sante fizik oswa mantal ki redwi kapasite ou pou travay;
- Ou fè omwens ke $217.50 pa semèn anvan taks;
- Ou gen timoun ki gen mwens ke 14 lane;
- Ou gen mwens pase 18 an oswa gen omwen 65 an;
- W'ap resevwa benefis andikap tankou SSI oswa SSD;
- Ou enskri nan lekòl oswa nan fòmasyon omwen mwatye tan;
- Ou ranpli yon lòt kondisyon egzansyon, tankou ou ansent oswa w'ap resevwa Konpansasyon Chomaj.
- W’ap fè fas a kondisyon sanzabri;
- Ou pa ka travay akoz vyolans domestik;
- W’ap pran swen yon moun ki malad oswa ki granmoun.

E si pwoblèm sante mwen redwi kapasite pou mwen travay?

- Pote fòm ki nan do feyè sa bay founisè swen sante w la, tankou doktè ou oswa terapis ou. Mande yo pou yo siyen kounye a.
- Moun ki gen fòm medikal la siyen ap kapab kenbe SNAP yo a.
- Menm si w'ap travay kounye a, se yon bon lide pou w fè siyen fòm sa a pou pwoteje SNAP ou a si lè travay ou yo ta vin chanje.
- Yon fwa egzijans travay yo kòmanse, ou ka soumèt fòm sa a ki siyen an bay Biwo Asistans Konte a pou ka kenbe benefis ou yo.

Fè yo siyen fòm egzansyon medikal sa a byen vit! Si ou pa fè sa, ou ka pèdi SNAP ou a apati de fen Novamm.

Vizite clsphila.org/SNAPchanges pou jwen dènye enfòmasyon sou kijan pou ou pwoteje SNAP ou.

CAO NAME AND ADDRESS

Pennsylvania
Department of Human Services

CASE IDENTIFICATION				
CO	RECORD NUMBER	CAT	CSLD	DIST
RECORD NAME				DATE

SNAP Medical Exemption Form

Dear Medical Provider or School Official:

For some students and certain other adults, eligibility for Supplemental Nutrition Assistance Program (SNAP) benefits may be restricted or time-limited. Individuals can be exempt from this requirement if they are medically certified as physically or mentally unfit for employment. Please help us determine whether your patient or student meets an exemption due to a physical or mental condition that limits their ability to work.

Patient/Student name: _____ Date of birth: _____

Patient/Student authorization:
I hereby authorize the release of the medical, rehabilitation participation, and/or reasonable accommodation information requested to the Pennsylvania Department of Human Services.

Signature: _____ Date: _____ /_____ /_____

Please answer the relevant questions below. Once completed, sign and date this form including your title or position in your agency.

Questions 1 and 2 may be completed by a 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.

Question 3 may be completed by any medical provider listed above or by a school official familiar with the services the individual is receiving. **Only complete Question 3 if the individual is enrolled in school half-time or more.**

1. Does this individual have a mental or physical condition or illness that reduces their ability to work?
   (NOTE: The condition may be either temporary or permanent and does not need to meet the Social Security standard to qualify. For students, consider the individual's ability to work <u>while also</u> attending school.)

   ☐ Yes ☐ No If **yes**, specify condition: _____

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

   ☐ Yes ☐ No If **yes**, specify program: _____

   If **ongoing**, specify date program will end: _____ /_____ /_____

3. Does this individual currently receive reasonable accommodations or other assistance from a postsecondary institution's disability access or reasonable accommodations office?

   ☐ Yes ☐ No If **yes**, specify condition: _____

By signing, I certify that all information provided above is true and accurate.

_____ _____
Name (please print) Title/profession

_____ _____ /_____ /_____
Signature Date form signed

_____
Address and phone number