SNAP 福利工作新规来袭，领取者们请注意！

立即行动，确保您的福利！

最早自 2025 年 9 月 1 日起，许多成年人需要每周工作 20 小时才能继续领取 SNAP 福利。此工作规定不适用于符合豁免条件的人士。如果您不符合豁免条件且每周工作时长不足 20 小时，那么 3 年内您最多只能领取 3 个月的 SNAP 福利。

若符合以下情况，您无需满足 SNAP 的工作要求：

- 您有身体或心理健康问题，导致工作能力下降；
- 您每周税前收入至少达到 217.50 美元；
- 您有未满 14 岁的子女；
- 未满 18 周岁或年满 65 周岁；
- 您正在领取残疾津贴（如 SSI 或 SSD）；
- 您正以至少半日制的方式在校学习或参加培训；
- 您符合其他豁免条件（例如怀孕或正在领取失业补偿金）
- 处于无家可归状态；
- 因家庭暴力无法工作；
- 正在照顾患病或年长人士；

如果我的健康问题影响了工作能力怎么办？

- 请将本通知背面的表格交给您的医疗服务提供者（如医生或治疗师）。请他们签字。
- 持有经签署的医疗证明者可继续享受 SNAP。
- 即使您现在有工作，也建议签署这份表格，以防将来工作时长发生变化时，能保障您的 SNAP 福利不受影响。
- 工作要求生效后，您可以将这份签署好的表格提交至县援助办公室，以继续领取福利。

请尽快让医疗服务提供者签署这份医疗豁免表格！否则，您最快可能在 11 月底失去 SNAP 福利。

请访问 clsphila.org/SNAPchanges 获取保护 SNAP 福利的最新信息。

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 while also 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