RESET

CAO NAME AND ADDRESS

pennsylvania
DEPARTMENT OF HUMAN SERVICES

CASE IDENTIFICATION				
CO	RECORD NUMBER	CAT	CSLD	DIST
RECORD NAME				DATE

ABAWD Time Limit Medical Exemption Form

Dear Medical Provider:

The Supplemental Nutrition Assistance Program (SNAP, formerly the Food Stamp program), limits Able-Bodied Adults without Dependents (ABAWD) to only 3 months of SNAP within 36 months. This rule applies unless the adult is working a minimum of 20 hours per week or is exempt from the time limit because the individual is medically certified as physically or mentally unfit for employment or falls within another exemption. Please help us determine whether your patient meets the exemption due to medical or mental issues and can be exempted from the ABAWD provisions.

Patient's name: _____ Date of birth: _____

Patient/participant's authorization:
I hereby authorize the release of the medical information and/or rehabilitation participation requested to the Pennsylvania Department of Human Services.

Signature: _____ Date: ____ /____ /_____

Please answer one or more of the following questions in the box below. Please sign and date this form including your title or position in your agency*.

1. Is this individual pregnant?

   ☐ Yes ☐ No If **yes**, due date? ____ /____ /_____

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

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

   Is this program ongoing? ☐ Yes ☐ No If **no**, date program will end: ____ /____ /_____

3. Does this patient have **a mental and/or physical illness or disability** which reduces his or her ability to financially support him or herself?

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

   Is this condition ongoing? ☐ Yes ☐ No If **no**, date it is expected to end: ____ /____ /_____

I certify that the information provided above is true and accurate.

_____ _____
Name (please print) Title/profession*

_____ ____ /____ /_____
Signature Date form signed

_____
Address and phone number

* This form may be signed by any of the following: 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.