ABAWD Medical Statement

Client/Patient Information

Client/Patient Name:

Address:

Case #: CIN: DOB:

The person named above requests verification of their health condition or program participation. Please fill out this form.You or the person should send the completed form to the local Department of Social Services at the address listed below.

Client/Patient Authorization

I authorize the release of medical information and/or documentation of participation in a substance use rehabilitation program requested to the Department of Social Services. I understand that this information will be treated as confidential.

Client Signature: Date:

Please answer any of the questions below that apply. Please sign and date this form. Include your profession or position in your organization.*

1) Is this person pregnant?

☐ Yes ☐ No ☐ Unknown ☐ NA

If yes, due date:

2) Is this person participating in a substance use treatment, rehabilitation, or counseling program?

☐ Yes ☐ No

If yes, what is the expected program end date:

3) Does this person have a temporary or permanent mental and/or physical health condition, which limits their ability to work 20 or more hours each week (80 hours monthly)?

☐ Yes ☐ No

If yes, please state the time frame the person will not be able to work 20 or more hours a week (80 hours monthly) because of this condition:

☐ less than 30 days ☐ 1-3 months ☐ 4-6 months

☐ 6-12 months ☐ more than 12 months/or indefinitely

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

Name (please print)

Title/profession*

Date form signed

Signature

Address

Phone

*This form may be signed by any of the following: physician, physician's assistant, nurse practitioner, osteopath, licensed or certified psychologist, substance use counselor, certified mental health counselor, licensed independent clinical social worker, licensed certified social worker, and certified midwife. For purposes of verifying a person's participation in a rehab or counseling program (Question #2), the director of the program or the individual's counselor may also sign this statement.

Please forward the completed form to the Department of Social Services:

Contact: **Phone #:**

Address:

Health Care Professionals:

You can help adults who have low income keep their Supplemental Nutrition Assistance Program (SNAP) benefits

SNAP benefits (formerly food stamps) allow people with low incomes to buy the food they need. Many SNAP recipients aged 18 to 64 who do not live with a child under 14 in the SNAP household are at risk of losing their SNAP benefits due to a SNAP rule referred to as Able-Bodied Adult Without Dependents (ABAWD) time limit. This rule restricts SNAP

eligibility to three months unless the person is working or participating in certain work activities for at least 20 hours per week.

With just a few minutes of your time, you can easily help.

A person who cannot work 20 or more hours a week because of a physical or mental health issue is not considered an ABAWD.

Frequently Asked Questions

What is the definition of someone who is physically or mentally "unfit for work" under the ABAWD rule?

Being determined physically or mentally unfit for work is a broader exemption than being disabled. A person is considered physically or mentally unfit for work if they have an illness, injury, or some other mental or physical limitation, whether temporary or permanent, that does not allow them to work at least 20 hours per week as required pursuant to federal ABAWD time limit rules. Some patients have mental or physical health conditions that prevent them from working altogether; others have conditions that allow them to work but they may not be able to work full time, or even 20 hours per week. This standard is much less strict than the Social Security standard for disability and does not require a specific diagnosis.

How do I verify that my patient is "physically or mentally unfit for work" based on their condition?

Fill out the one-page ABAWD Medical Statement Form. Include the expected time frame of the condition and your signature. **A variety of healthcare professionals can sign this form** including: a doctor, doctor's assistant, a nurse, nurse practitioner, licensed or certified psychologist or social worker.

Submit Form

Note: The Submit button is not compatible with web-based email browsers. Please use a desktop email application to submit this form.