**STATE OF WISCONSIN**
**DEPARTMENT OF HEALTH SERVICES**
Division of Health Care Access and Accountability
F-01598 (08/2015)

**MAS**

# KEV ZAM RAU KEV UA HAUJ LWM VIM MUAJ MOB NKEEG RAU COV NEEG UAS TSEEM UA TAU HAUJ LWM UAS TSIS MUAJ COV NEEG UAS TSEEM TOS LAWV PAB

## MEDICAL EXEMPTION FROM WORK REQUIREMENT FOR ABLE-BODIED ADULTS WITHOUT DEPENDENTS

**Cov Lus Qhia rau Tus Kheej Txhua Tus**
Nqi lus 1 yuav tsum muab ua kom tiav los ntawm koj los yog koj lub county los yog tribal tus neeg ua hauj lwm. Nqi lus 2 thiab Nqi lus 3 yuav tsum muab ua kom tiav los ntawm ib tus kws muab kev kho mob, xws li ib tus kws kho mob uas muaj ntawv pov thawj, ib tus kws pab tus kws kho mob, ib tus kws tu mob pab kws kho mob, ib tus kws tu neeg mob uas muaj ntawv pov thawj, ib tus kws kho fab laj lim tswv yim nyuaj siab mob hlwb, ib tus kws ua hauj lwm rau tib neeg, los yog ib tus kws pab muab tswv yim. **Yuav tsum muab daim foos uas ua tiav txhij txhua thiab muab xa rov qab rau koj lub county los yog tribal lub chaw ua hauj lwm. Muab ib daim qauv luam ntawm daim foos uas muab ua tiav txhij txhua khaws cia rau hauv koj cov ntaub ntawv.**

**Instructions for Medical Providers**
The individual listed in Section 1 below has been referred to the FoodShare Employment and Training (FSET) program and is able to participate in the FSET program for 80 hours per month (an average of 20 hours per week) in order to maintain FoodShare eligibility. If the individual is unfit for employment due to a physical or mental health condition, the individual may be exempted from this work requirement. By filling out Section 2 and Section 3 below, you are certifying that the applicant is physically or mentally unfit for employment. Return this form to the individual.

**Note:** This form should only be used to determine whether the individual should be exempted from the above work requirement. It should not be used to determine any type of formal disability or disability benefits, including Presumptive Disability or Elderly, Blind or Disabled Medicaid, or used with a disability application through the Social Security Administration (SSA) or the Disability Determination Bureau (DDB).

**Nqi lus 1 – Qhia Kom Paub Txog Tus Kheej**

| Npe – Tus kheej | Hnub Yug | Tus Case Naj Npawb |
|---|---|---|
| | | |

**Section 2 – Work Exemption**

☐ I have determined that the above-named individual is physically and/or mentally unfit for employment and should be exempted from a work requirement.

| Begin Date – Condition (if applicable) | End Date – Condition (if applicable) |
|---|---|
| | |

**Section 3 – Medical Provider Information**

Name – Medical Provider (Last, First MI)

Hospital / Clinic Name

Address

| City | State | Zip Code |
|---|---|---|
| | | |

By signing below, I am certifying that the individual listed in Section 1 is physically or mentally unfit for employment.

| **SIGNATURE** – Medical Provider | Date Signed |
|---|---|
| | |

Reset Form