

**EXENCIÓN MÉDICA DE REQUISITO DE TRABAJO
PARA ADULTOS APTOS SIN DEPENDIENTES
MEDICAL EXEMPTION FROM WORK REQUIREMENT FOR ABLE-BODIED
ADULTS WITHOUT DEPENDENTS**

Instrucciones para las personas

La Sección 1, la debe llenar usted o su trabajador de la agencia del condado o tribal. La Sección 2 y la Sección 3, la debe llenar un proveedor médico, tal como médico con licencia, asistente médico, enfermera especializada, enfermera con licencia o registrada, psicólogo, trabajador social o consejero. **El formulario se tiene que enviar a su agencia del condado o tribal. Se mantendrá una copia del formulario lleno en su expediente.**

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).

Sección 1 – Información de la persona

Nombre de la persona	Fecha de nacimiento	Número de caso
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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)
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Section 3 – Medical Provider Information

Name – Medical Provider (Last, First MI)

Hospital / Clinic Name

Address

City	State	Zip Code
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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
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