Work Requirements Are Coming for Many People on SNAP.

Take Action to Keep Your Benefits!

Starting as soon as September 1, 2025, many adults will need to work 20 hours a week to keep their SNAP. These work rules do not apply to people who meet an exemption. If you are not exempt or working 20 hours a week, you can only get 3 months of SNAP in 3 years.

You DON'T have to meet SNAP work requirements if:

- You have a physical or mental health condition that reduces your ability to work;
- You are earning at least $217.50 a week before taxes;
- You have children under the age of 14;
- You are over age 65 or under age 18;
- You are getting a disability benefit like SSI or SSD;
- You are enrolled in school or training at least half time;
- You meet another exemption, like you are pregnant or receiving Unemployment Compensation

What if my health issue reduces my ability to work?

- Take the form on the back of this flyer to your doctor. Ask them to sign now.
- Even if you work now, it's a good idea to get this form signed to protect your SNAP if your hours change.
- Once work requirements start, you can submit this signed form to the County Assistance Office to keep your benefits.

Get this medical exemption form signed soon! If you don't, you could lose your SNAP as soon as the end of November.

We do not yet know all the rules or when exactly they will go into effect, but we do know that people with the medical form signed by their medical provider will be able to keep their SNAP.

July 2025

RESET

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 <u>while also</u> 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