

Work Requirements Are Coming for Many People on SNAP.

Take Action to Keep Your Benefits!

Starting 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;
- You are experiencing homelessness;
- You are unable to work because of domestic violence.

What if my health issue reduces my ability to work?

- Take the form on the back of this flyer to your healthcare provider, like your doctor or therapist. Ask them to sign now.
- People with the signed medical form will be able to keep their SNAP.
- 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 ASAP! If you don't, you could lose your SNAP as soon as the end of November.

Visit clsphila.org/SNAPChanges for the most up-to-date information about how to protect your SNAP.



CAO NAME AND ADDRESS

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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.**

- 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 while also attending school.)
 Yes No If **yes**, specify condition: _____
- 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: ____ / ____ / ____
- 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