DHS Only
Date Received: ___________
SSR Name: ______________

SNAP Work Requirement Medical Form

Purpose: This form is used by the District of Columbia Department of Human Services (DHS) to verify a physical or mental disability, illness, injury, or condition for purposes of exemption from the DC Supplemental Nutrition Assistance Program (SNAP) work requirements.

WHO CAN FILL OUT THIS FORM?

Authorized Professionals: This form may be completed by any qualified professional who can provide competent medical evidence about the individual's health or functional limitations. The examples below are common types of eligible professionals:

Medical & Mental Health	Physicians, Physician Assistants, Nurse Practitioners, Midwives, Psychologists, Social Workers, Mental Health Counselors, Community Health Workers, Osteopaths, Podiatrists, Optometrists, Audiologists, or a Designated Representative of Physician's Office
Specialized Therapy	Physical, Speech, or Occupational Therapists
Support Services	Drug and Alcohol Counselors, Rehabilitation Staff, Homeless Outreach Counselors, or any Designee
Other	Any other health or medical personnel qualified to provide competent medical evidence

By signing this form, the professional confirms that the individual meets at least one of the following:

- Has a physical or mental disability, illness, injury, or condition that temporarily or permanently reduces their ability to work;
- Is pregnant;
- Is a regular participant in substance use, drug, or alcohol rehabilitation, recovery, or counseling program; or
- Is currently receiving services from a Substance Use Disorder (SUD) provider or Recovery Support Service (RSS).

HOW TO SUBMIT — Keep a copy for your records

How to Submit: The patient/participant or professional should return this completed and signed form the DHS Economic Security Administration (ESA) using one of the following methods.

Online	Mail	Drop-Off at Service Center	Fax
Scan to complete on Districtdirect.dc.gov Scan to complete on **District Direct Mobile App** *iPhone & Android Compatible*	District of Columbia Department of Human Services Economic Security Administration Case Record Management Unit P.O. Box 91560 Washington, DC 20090	**Anacostia** 2100 Martin Luther King Avenue, SE **Congress Heights** 4049 South Capitol Street, SW **Fort Davis** 3851 Alabama Avenue, SE **H Street** 645 H Street, NE **Taylor Street** 1207 Taylor Street, NW	202-671-4400

SNAP Work Requirement Medical Form

SECTION 1 — PARTICIPANT INFORMATION

Patient/Participant Name:			
Address:			
Case Number (if known):	City:	ZIP:	State:
Phone Number:		Date of Birth (MM/DD/YYYY):	

SECTION 2 — AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the provider listed below, who is receiving this form, to release the medical information and/or rehabilitation participation information requested on this form to the District of Columbia's Department of Human Services for the purpose of determining whether I may be excused from work requirements. The authorization expires when my participation in DC SNAP ends.

Name of Provider:	
Patient/Participant Signature:	Date (MM/DD/YYYY):

Important Information About Your Rights

You have the right to **revoke this authorization at any time** by submitting a written request to DC DHS ESA by mail, fax, in person, or through the District Direct portal or mobile app.

Once your information is shared with DHS, it **may no longer be protected by the same medical privacy laws** and could be subject to resharing.

Your provider may NOT condition your treatment, payment, enrollment, or eligibility for benefits on whether you sign this authorization.

SECTION 3 — PROVIDER VERIFICATION

Please answer any questions that apply.

#	Question	Response
1	Does this individual have a temporary or permanent mental and/or physical illness, disability, injury, or other condition which reduces or impairs their ability to work?	☐ Yes ☐ No
	If YES, please indicate expected duration of the individual's illness/disability (from today's date):	☐ Less than 30 days ☐ 1–3 months ☐ 3–6 months ☐ 6–9 months ☐ 9–12 months ☐ Over 12 months ☐ Permanent
2	Is this individual pregnant?	☐ Yes, Due Date: ________________ ☐ No
3	Is this individual a regular participant in a substance use, drug, or alcohol treatment, rehabilitation, recovery, or counseling program?	☐ Yes ☐ No
	If YES, list Program Start Date & Anticipated End Date (MM/DD/YYYY):	Start Date: ________________ End Date: ________________
4	Is this individual currently receiving ongoing services from a Substance Use Disorder (SUD) provider or Recovery Support Service (RSS)?	☐ Yes ☐ No
	If YES, list Program Start Date & Anticipated End Date (MM/DD/YYYY):	Start Date: ________________ End Date: ________________

SECTION 4 — PROVIDER CERTIFICATION

We are unable to accept this form without your signature. Please **sign, date** and include your **profession or position** within your agency or organization this form.

Full Name:	Title/Profession:
Organization:	Phone:
Address:	

I certify that the information provided above is true and accurate, and attest that I am able to provide competent medical evidence to support this determination.

Signature:	Date Signed (MM/DD/YYYY):