HUMAN SERVICES
DEPARTMENT

Susana Martinez, Governor
Brent Earnest, Secretary
Marilyn Martinez, Director

Manual Revision Memorandum

ISD-MR 15-22

TO: **ISD Employees**

FROM: **Marilyn Martinez, Director, Income Support Division**

DATE: **December 30, 2015**

RE: **Forms Manual Revision for FSP 300 SNAP Medical & Caretaker Exemption Form**

Form FSP 300 "SNAP Medical & Caretaker Exemption Form" has been created to allow the individual's medical provider an opportunity to notify ISD of an individual's status of being "unfit for work" if the unfitness is not obvious.

Instruction:

New- FSP 300 SNAP Medical & Caretaker Exemption Form

This form has been posted to the forms drive:**disfasv025\ISDForms**

If you have questions regarding this MR, please contact Marisa Vigil at (505) 827-1326 or by e-mail at Marisa.Vigil@state.nm.us.

Attachment: FSP 300 SNAP Medical & Caretaker Exemption Form

HUMAN SERVICES DEPARTMENT

SNAP Medical & Caretaker Exemption Form

Dear Medical Provider:

The Supplemental Nutrition Assistance Program (SNAP) limits able bodied adults to the receipt of 3 months of SNAP benefits every 36 months unless the adult is working or participating in up to 20 hours per week or is excepted from participation pursuant to 7 CFR 273.24. Please help us decide whether your patient is "unfit for work" as indicated by 1, 2, or 3 below.

Patient name:_____Date of birth: _____/_____/_____

Patient/participant authorization: I hereby authorize the release of the medical information requested to the New Mexico Human Services Department.

Signature:_____Date:_____/_____/_____

Please answer one or more of the following questions in the box below. Please sign and date this form including your profession or position in your agency*.

1. Is this individual a participant in a mental health counseling program, or a drug or alcohol treatment or counseling program, or a vocational rehabilitation program?

   ☐ Yes ☐ No If yes, specify program: _____

   Is this program ongoing? ☐ Yes ☐ No. If no, date program will end: Date: ____/____/_____

2. Does this patient have a mental and/or physical illness or disability, temporary or permanent, which makes him/her unfit to work?

   ☐ Yes ☐ No If yes, specify disability or illness: _____

   Is this condition ongoing? ☐ Yes ☐ No. If No, date it is expected to end:____/____/_____

3. Does this patient have a mental and/or physical illness or disability, temporary or permanent, which needs somebody assisting them in their activities of daily living?

   ☐ Yes ☐ No If yes, specify the individual(s) that provide this function: _____

   Is this condition ongoing? ☐ Yes ☐ No. If No, date it is expected to end:____/____/_____

I certify that the information provided above is true and accurate.

Print Name **Title/Profession***

Signature **Date Form Signed**

Address and Phone Number

*This form may be signed by any of the following: physician, physician's assistant, designated representative of the physician's office, nurse practitioner, osteopath, psychologist, phycologist, drug and alcohol abuse counselor, mental health counselor, social worker, midwife, Native American practitioners "medicine men", podiatrist, audiologist, physical therapist, occupational therapist, optometrist, or any other medical personnel whose services may be reimbursed by Medicaid.

FSP 300 11/15/2016

Rescinded 03/07/2016

Notice of Rights

Special Needs Information If you are a person with a disability and you require this information in an alternative format, or require a special accommodation to participate in any public hearing, program or services, please contact the Human Services Department, American Disabilities Act (ADA) coordinator at 1-505-827-7701 or through the New Mexico Relay System TDD at 1-800-659-8331 or by dialing 711. The Department requests at least 10 days advance notice to provide requested alternative formats and special accommodations. (Revised 09/15/14)

Your Civil Rights Nondiscrimination Statement

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992.

Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue,
SW Washington, D.C.
20250-9410;

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov.

This institution is an equal opportunity provider. (Revised 10/14/15)

To file a complaint through HSD of discrimination and/or rude treatment regarding a program receiving Federal or State financial assistance, a complaint form is available at the ISD office or you may write to: NM Human Services Department, ISD Civil Rights Director, P.O. Box 2348, Santa Fe, NM 87504-2348 or by fax (505) 827-7241.

Confidentiality

All information you give to HSD is confidential. This information will be given to HSD employees who need it to manage the programs for which you have applied. Confidential information may also be released to other federal and state agencies. All information will be used to determine eligibility and/or to provide services. (Revised 07/15/14)

This information may be given to other Federal and State agencies for official examination, and to law enforcement officials for the purpose of picking up persons fleeing to avoid the law. If you get benefits that you were not eligible for and have to pay them back, this is called a claim. If your household gets a claim

against it, the information on this application including all Social Security Numbers, may be given to Federal and State agencies, as well as private claims collection agencies for claims collection action. You only have to give U.S. Citizenship and Social Security Numbers for those household members that you are applying for. You do not need to be a U.S. Citizen to apply.

Receiving SNAP/food, energy or medical assistance will not prevent you from becoming a lawful permanent resident or U.S. Citizen. Non-citizen immigrants not requesting assistance for themselves do not need to give immigration status information, Social Security Numbers, or other similar proofs; however, they must give proof of income and things they own because part of their income and things they own may count towards the household's eligibility for assistance. Certain benefits may be available for people without a Social Security Number; ask ISD.

We also check with other agencies, the federal Income and Eligibility Verification Service (IEVS) and The Public Assistance Reporting Information System (PARIS) about the information that you give us. This information may affect your household eligibility and benefit amount.