**STATE OF WISCONSIN**
**DEPARTMENT OF HEALTH SERVICES**
Division of Health Care Access and Accountability
F-01598 (08/2015)

**MAS**

# MEDICAL EXEMPTION FROM WORK REQUIREMENT FOR ABLE-BODIED ADULTS WITHOUT DEPENDENTS

**Instructions for Individuals**
Section 1 should be filled out by you or your county or tribal agency worker. Section 2 and Section 3 should be filled out by a medical provider, such as a licensed physician, physician's assistant, nurse practitioner, licensed or registered nurse, psychologist, social worker, or counselor. **The completed form must be returned to your county or tribal agency. A copy of the completed form will be kept in your case file.**

**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).

**Section 1 – Individual Information**

| Name – Individual | Date of Birth | Case Number |
|---|---|---|
| | | |

**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) |
|---|---|
| | |

**Section 3 – Medical Provider Information**

Name – Medical Provider (Last, First MI)

Hospital / Clinic Name

Address

| City | State | Zip Code |
|---|---|---|
| | | |

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 |
|---|---|
| | |

**RESET FORM**