

Joe Lombardo
Governor

Laura Rich
Director



**DEPARTMENT OF
HUMAN SERVICES**
DIVISION OF SOCIAL SERVICES
Working for the Welfare of ALL Nevadans.



Robert H. Thompson
Administrator

Case Name: _____

Case ID: _____

RE: _____
(Name)

_____ (Street/Residence Address)

The above-named individual is currently applying for or receiving Supplemental Nutrition Assistance Program (SNAP) benefits through the Nevada Division of Social Services (DSS). Federal SNAP regulations require certain adults to meet work participation requirements unless they are determined to be physically or mentally unable to engage in work activities.

The individual has indicated that they may have a physical and/or mental condition that limits their ability to work. DSS is requesting verification solely for the purpose of determining whether the individual is able to participate in work activities totaling 80 hours per month (approximately 20 hours per week).

DSS does **not** require diagnosis, treatment records, or detailed medical history. Please provide only information necessary to assess functional work capacity.

MEDICAL PROVIDER STATEMENT

(To be completed by a licensed medical professional)

Patient Name: _____

Date of Birth: _____

Based on your professional evaluation, please indicate the patient's current ability to participate in work activities totaling 80 hours per month:

- The individual is able to engage in work activities totaling 80 hours per month.
- The individual is unable to engage in work activities totaling 80 hours per month (please describe below).
- The individual has limitations affecting work capacity (please describe below).

If unable or limited, please indicate:

Is the condition:

- Temporary
- Permanent
- Indeterminate at this time

If temporary or indeterminate, anticipated duration of limitation:

Brief lay description of functional limitation (please do not include diagnosis unless necessary):

Additional relevant functional information (if applicable):

Provider Name (Printed): _____

Practice Name: _____

Phone: _____

Provider Signature: _____

Date: _____