



London Breed, Mayor

Department of Human Services  
Department of Aging and Adult Services  
Office of Early Care and Education

Trent Rhorer, Executive Director

### Medical Exemption Form

Dear Medical Provider\*:

The CalFresh program (formerly the Food Stamp program), limits certain adults between the ages of 18-49 to only 3 months of CalFresh. This rule applies unless the adult is working a minimum of 20 hours per week or qualifies for an exemption. If the individual is unable to work due to a physical or mental health condition, the individual may be exempted from this work requirement. Please help us determine whether your patient meets the medical exemption by completing the sections below.

**Patient/participant's authorization:**

I \_\_\_\_\_ hereby authorize the release of the medical information  
(patient/participant's name)  
requested to the San Francisco Human Services Agency.

**Medical determination of exemption from CalFresh Work Requirement**

Patient's name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

**This patient has a mental and/or physical condition, which restricts their ability to work 20 hours week.**  
Please state how the condition restricts the patients ability to work 20 hours per week and the anticipated duration:

\_\_\_\_\_  
\_\_\_\_\_

**This patient is pregnant. If yes, expected delivery date:** \_\_\_\_\_

**Medical Provider Information\*:**

\_\_\_\_\_  
Name of Medical Provider (First, Last) Title/Position

\_\_\_\_\_  
Name of Hospital / Clinic / Organization Address of Hospital / Clinic / Organization

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

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\* Qualified medical or mental health professionals include, but are not limited to: audiologist, dentist, optometrist, osteopath, designated representative of the physician's office, drug and/or alcohol counselor, mental health counselor, psychologist, midwife, nurse, nurse practitioner, physical therapist, occupational therapist, physician, physician assistant, podiatrist, social worker, etc.

This form may be returned via

**Mail:** P.O. Box 7988, San Francisco, CA 94120-7988

**Fax:** (415) 558-1184

**Online:** [www.MyBenefitsCalWIN.org](http://www.MyBenefitsCalWIN.org)

**In Person:** 1235 Mission Street

**Email:** [food@sfgov.org](mailto:food@sfgov.org)