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MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION

SNAP (FOOD STAMPS) SUMMARY TO DETERMINE FITNESS FOR WORK

Mandatory information needed for MRT decision			COUNTY NAME	FAMIS COUNTY NUMBER
INDIVIDUAL NAME (FIRST, MIDDLE, LAST)			INDIVIDUAL DCN	DATE OF BIRTH (MONTH/DAY/YEAR)
ELIGIBILITY SPECIALIST	FAMIS USERID	LOAD	DATE OF APP/REAPP/REVIEW	DATE SUBMITTED TO MRT

1. What keeps the participant from working at least 20 hours per week?

2. Does the participant need an exam?

☐ **Yes** ☐ **No (If no, complete section 3)**

3. RECORD OF TREATMENT

Treating physician 1	Address
Treating physician 2	Address
Hospital or clinic - name	Address
Hospital or clinic - name	Address

Medical Review Team determination
MRT has reviewed the relevant documentation and certifies this individual:

Able to work at least 20 hours per week ☐	Physically or mentally unfit to work at least 20 hours per week ☐		More information is needed ☐ Specify what is needed:
	DATE EFFECTIVE	DATE OF NEXT REVIEW	

Primary diagnosis/disability/recommendation

☐ REFER TO VOCATIONAL REHABILITATION

MRT PHYSICIAN	DATE
MRT COORDINATOR	DATE