Snap E&T Provider Determination

Complete this form and send via encrypted email to anastasia.polda@state.mn.us within 10 days of determination being made.

Date Determination Made:

Participant Name:

Participant MAXIS #:

Provider:

Provider Staff Name:

Provider Staff Phone:

Provider Staff E-mail:

The participant listed above has expressed a desire to work with SNAP E&T. I have addressed their employability and have determined they are unable to benefit from the SNAP E&T offerings at:

The reason for this determination is:

I advise the county or tribal eligibility worker to (complete one):

Re-assess this participant's ability to work. This participant is unable to work due to:

Re-refer the participant to another provider or service. I recommend the participant seek services from:

I have informed the participant of this determination and the reasons for it.

Provider Signature:

Date: