Participants' County & Agency SNAP E&T Service Agreement

Participant Information

Participant Information	Provider Information
Participant's Name (First, Last)	Date
Social Security Number	Community Agency Name
Maxis Case Number	Employment Counselor Name/Phone/Email
County of Residence	County Name (if different than county of residence)
SNAP E&T Status Mandatory (ABAWD)	County Contact Name/Phone/Email

Employment Plan Start Date	Employment Plan End Date

Employment Goal(s)

Additional Comments

Employment Plan/Client Responsibility

I understand that a Supplemental Nutrition Assistance Program (SNAP) Employment Plan is required. I have read my plan and know that I must complete the activities in the plan to help me reach my goals.

I understand that I must:

- Maintain regular contact with my Employment Counselor
- Make satisfactory progress and follow through with my Employment Plan
- Inform my Employment Counselor of any changes in employment status, residence, or need to update Employment Plan
- Provide Employment Counselor documentation of a minimum of 20 hours of work or work search activities per week

✓ I certify that I have:
  - Viewed or received SNAP E&T orientation
  - Discussed the above information with my Employment Counselor and I agree to follow it

✓ I authorize the release of information for the Community Agency listed above to communicate with the County regarding my progress in the SNAP E&T program

Participant's Signature	DATE
Employment Counselor's Signature	DATE

Revised 10.20.17