MARYLAND DEPARTMENT OF HUMAN SERVICES

SNAP E&T Reverse Referral Form

The customer listed below has requested to participate in the SNAP E&T Program indicated below. Please validate their eligibility to participate in the program and return this document to the listed provider within 48 hours.

To be completed by the Program

Customer Name: _____ Customer ID:_____

Date of Birth: _____

Cell Phone Number: _____

Residential Address: _____

Mailing Address: _____

County of Residence: _____

Primary language: □ English □ Spanish □ Other (specify): _____

SNAP E&T Program

Program:	Curriculum:
	Date of enrollment::
Address:	

Provider Signature:_____ Phone number:_____

Email address:_____

To be completed by DHS Staff

Receiving SNAP: Yes ☐ No ☐

ABAWD?: Yes ☐ No ☐

DHS Signature: _____ Phone number:_____

Email:_____