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OFFICIAL MEMORANDUM

DATE: September 22, 2014  
TO: CSTAR, PR+, DOC and SROP Community Treatment Providers  
FROM: Nora Bock, DBH Director of Adult Community Treatment *NB*  
RE: SB 680 – Food Stamps For Individuals with Drug Felonies

Recent legislation signed by the Governor may affect some of our consumers. Senate Bill 680 {Section 208.247} allows individuals with certain drug felony convictions to apply for and receive food stamps should they meet requirements established by the Department of Social Services (DSS). A consumer who is participating in, has completed, or is on a waiting list for substance use treatment at your facility may present to you the attached form. This form, developed by DSS, requires completion by your program staff.

Please contact the Family Support Division at (573) 751-3178 if you have any questions regarding this process or the document that may be presented to you.

Thank you.

NB:ldn

Attachment

ec: Laurie Epple  
Rhonda Turner  
Natalie Fornelli  
Brent McGinty  
Area Treatment Coordinators



**MISSOURI DEPARTMENT OF SOCIAL SERVICES  
 FAMILY SUPPORT DIVISION  
 DRUG CONVICTION EXCEPTION VERIFICATION FOR SUBSTANCE ABUSE  
 TREATMENT PROGRAMS**

Please mark yes or no where indicated regarding the following person's substance abuse treatment program status. Any individual who has been convicted of manufacturing or distribution of a controlled substance is not eligible for Food Stamp benefits. Only those who have been convicted of use or possession of a controlled substance, who meets the criteria, may be eligible to participate in the Food Stamp Program.

NAME: \_\_\_\_\_ DCN: \_\_\_\_\_

	Is the above person currently successfully participating in a substance abuse treatment program approved by the Division of Alcohol and Drug Abuse? Treatment Center Name: _____ Start Date: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Is the above person currently enrolled in a substance abuse treatment program approved by the Division of Alcohol and Drug Abuse but on a waiting list? Treatment Center Name: _____ Date of Enrollment: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Has the above person successfully completed a substance abuse program approved by the Division of Alcohol and Drug Abuse? Treatment Center Name: _____ Completion Date: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Has a certified treatment provider from Division of Alcohol and Drug Abuse determined the above person does not need substance abuse treatment? Treatment Center Name: _____ Determination Date: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Has the individual demonstrated sobriety through urinalysis testing? Date of Test: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Title: \_\_\_\_\_

Under the penalty of perjury, I certify that I have given true, accurate, and complete statements to the best of my knowledge.