Self-Attestation Form for Item E6
If exit is not due to unsubsidized employment, other reason for exit

On this date, I, _____*(Name of Participant)*, certify that I am unable to continue participating in the SCSEP program and unable to work based on one of the following:

_____ I have a documented health/medical exclusion, that is:

1. I am in the care of Dr. _____ *(Name of Doctor)*, **and**
2. I have been informed by Dr. _____ *(Name of Doctor)*, that
   a. my medical condition is expected to last at least 90 days, **and**
   b. my medical condition prevents me from continued participation in the SCSEP program or from working.

_____ I have a documented family care exclusion, that is:

1. I am providing care for my family member,_____ *(Name of Relative and Relationship to Participant)*,
2. My family member is in the care of Dr. _____ *(Name of Doctor)*,
3. I have been informed by Dr. _____ *(Name of Doctor)*, that the medical condition is expected to last at least 90 days, **and**
4. My family member requires a level of care which prevents me from continued participation in the SCSEP program or from working.

_____ I am institutionalized, that is:

1. I am receiving 24-hour care at _____ *(Name of Facility)*, which is a facility such as a prison or a hospital, **and**
2. I have been informed by _____ *(Name and Position)* that I am expected to remain at this facility for at least 90 days, which prevents me from continued participation in the SCSEP program or from working.

_____ _____

(Signature of Applicant) *(Date)*