Request for ABAWD Work Program Exemption

There have been changes to the Supplemental Nutrition Assistance Program (SNAP). Now, Able-Bodied Adults Without Dependents (ABAWDs) are defined as SNAP recipients ages 18-64, who are not parents of minor children and who are able to work but are not working a total of 80 hours per month. Also, ABAWDs can only receive SNAP benefits for three (3) months in a three (3) year period if they do not meet the ABAWD work requirements or are exempt from the requirements. Use this form to tell us about your situation so we can determine if you are exempt from or already meeting the work program requirements. You must provide DHS this completed form and verifications to be considered for an exemption to the ABAWD work requirements. If you have questions or need assistance, our Call Center staff can be reached by calling 855-697-4347.

If you have a customer portal account with www.healthyrhode.ri.gov, you may upload this form and your verifications there.

Section 1: Client Information

Name: _____

Address: _____

Phone Number: _____ RIBridges Case Number (If known): _____

Section 2: Requested Information. Check all that apply to you.

☐ I am working a total of 80 hours per month at the federal minimum wage, including self-employment**.** You must provide one of these verifications:

- last 4 weeks of pay stubs;
- a signed and dated letter on employer's letterhead with anticipated weekly hours and pay per hour;
- proof of your self-employment.

☐ I am unfit for work and am physically or mentally unable to work a total of 80 hours per month.
You must provide one of these verifications:

- DHS medical form (C1b) from the center or provider;
- A completed and signed Community Partner ABAWD Exemption Request form obtained from the DHS website or a community partner agency where you receive supports and services;
- A letter from a medical or mental health provider stating you are not able to work a total of 80 hours per month;
- Verification of disability payments (SSI, SSDI, VA disability, TDI).

☐ I am in a substance abuse treatment program.
Name of the program: _____
You must provide one of these verifications:

- DHS medical form (C1b) from the center or provider
- A document from the center or provider that shows your participation in the treatment program.

☐ I am in a SNAP household living with a child under age 14. (This can be your own child or sibling, or the child of another family with whom you live.)
Name and age of the child: _____

☐ I am pregnant (any stage of pregnancy). Your due date (if known): _____
You must provide verification of pregnancy.

☐ I am a parent or individual responsible for the care of a dependent child under the age of 6 or a person with a disability. (Note: The person does not need to live with you.)
Name and age of the child: _____
Name of the incapacitated person for whom you provide care: _____
You must provide verification of the individual's incapacitation.

☐ I am in a work-training program or SNAP E&T.
Name of the program: _____
You must provide a document from the program provider that shows your participation in the work-training program, including the hours that you attend the program each week.

☐ I go to school at least half-time.
Name of School: _____
You must provide us with a document that confirms your enrollment is at least half-time.

☐ I am getting unemployment benefits, or I have applied for unemployment benefits.
You must provide a copy of your approval notice or application submission confirmation.

☐ I am doing volunteer work or "community service" work.
You must provide us either a signed and completed copy of the ABAWD Combined Activity Reporting Form or a letter from the place where you do volunteer work. The letter must include:

- the phone number and address where you volunteer;
- the number of hours (on average) that you volunteer each month; and
- the signature of a staff person and the date.

Section 3: Client Signature

Under penalty of perjury, I attest that all of the information contained in this form is true. I understand that I am breaking the law if I give false information and can be punished under federal law, state law or both.

Signature _____ Date_____

HOW TO GET THIS FORM TO DHS

Submit the completed and signed form through the following pathways:

- Mail to RI Department of Human Services, P.O. Box 8709, Cranston, RI 02920-8787;
- Drop off in person or at a Drop Box Office location listed at https://dhs.ri.gov/about-us/dhs-offices;
- Log in and upload to your Customer Portal account at http://www.healthyrhode.ri.gov; or
- Access through the HealthyRhode Mobile App in the APP store or Google Play

For questions, call: 1-855-MY-RIDHS (1-855-697-4347)

Note: If you are applying or recertifying at this time, you may submit this completed and signed form with your DHS application or renewal documents.