



Request for ABAWD Work Program Exemption

SNAP rules say that you are limited to 3 months of SNAP benefits in a 36 month period unless you work, volunteer, or participate in certain employment and training programs. This rule does not apply to all clients. 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. Give the completed form and any verification to DHS. If you have questions or need help, call 855-697-4347.

DHS forms may be downloaded from <https://healthyrhode.ri.gov>

If you have an account with <https://healthyrhode.ri.gov>, you may upload verification there.

Section 1: Client Information

Name:

Address:

Phone Number:

Case Number or Last 4 digits of SSN:

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

I am working at least 20 hours per week on average, including self-employment. Give us 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 20 hours per week. Give us one of these verifications:

- DHS medical form (C1b)
- A community partner exemption form
- A letter from a medical or mental health provider stating you are not able to work 20 hours per week
- Verification of disability payments (SSI, SSDI, VA disability, TDI)

I am in a substance abuse treatment program.

Name of the program:

Please provide us with one of these verifications:

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

I am in a SNAP household living with a child under age 18. (This can be your own child or sibling, or the child of another family you live with.)

Name and age of the child:

I am pregnant (any stage of pregnancy). Your due date (if known):

I am experiencing homelessness.

I am under age 25 and was in foster care on my 18th birthday.

I am a veteran who served in the armed forces of the United States and was honorably or dishonorably discharged.

I am caring for a person with a disability. (The person does not need to live with you.)

Name of the person for whom you provide care:

What you do for this person:

I am in a work-training program or SNAP E&T.

Name of the program:

Please provide us a document that shows your participation in the work-training program that includes the hours that you attend the program each week.

I go to school at least half-time.

Name of School:

Please provide us with a document that confirms your program is at least half-time.

I am getting unemployment benefits, or I have applied for unemployment benefits.

I am doing volunteer work or “community service” work.

Please provide us with 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
- the signature of a staff person and the date.

Section 3: Client Signature

Signature

Date

HOW TO GET THIS FORM TO DHS:

- Upload it to your Customer Portal account at <https://healthyrhode.ri.gov> or Mobile App
- Mail it to: State of RI, PO Box 8709, Cranston, RI 02920-8787
- Bring it to a DHS field office in Newport, Pawtucket, Providence, Wakefield, Warwick, or Woonsocket.

If you are applying or recertifying at this time, you may submit it with your DHS forms.