**Request for Exemption from the SNAP Time Limit**

Supplemental Nutrition Assistance Program (SNAP) rules limit most adults who are between 18 and 49 years old and do not have dependents to 3 months of SNAP benefits in a 36-month period. We call these individuals able-bodied adults without dependents, or “ABAWDs.” We have determined that you are an ABAWD. To get benefits for more than 3 months, an ABAWD must work, participate in an employment and training program, and/or volunteer for 20 hours per week on average, or participate in a workfare program. Under certain circumstances, an ABAWD may be exempt from these rules. Please use this form to tell us about your situation so we can determine if you are exempt from or already meeting the ABAWD work requirements.

**Section 1:** Client Information

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

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 2:** Check **all that apply to you** and give us the requested information.

[ ]  I am working at least 20 hours per week on average, including through self‐employment**.**

Give us **one** of these verifications:

[ ]  Last 4 weeks of pay stubs, or

[ ]  A signed and dated letter on your employer’s letterhead with your anticipated weekly

 hours and pay per hour, or

[ ]  Proof of your self‐employment.

[ ]  I am physically or mentally unable to work 20 hours per week. This may be because of a physical or mental impairment, including addiction to drugs or alcohol.

We will give you a SNAP ABAWD Medical Report form for you to have completed and returned to us. Alternatively, you can provide other proof from your medical or mental health provider stating that you are not able to work 20 hours per week.

[ ]  I am in a substance abuse treatment program.

Name of the program: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

We will give you a SNAP ABAWD Medical Report form for you to have completed and returned to us. It must show your participation in the treatment program.

[ ]  I am pregnant.

Give us proof that you are pregnant.

[ ]  I am homeless (I am living on the street or in a shelter, or do not know where I will sleep each night on a predictable basis).

Give us **one** of these verifications:

[ ]  A letter from a social worker stating that you are homeless, or

[ ]  Proof you are staying at a homeless shelter.

[ ]  I live with a child under age 18. (This can be your own child or sibling, or the child of another family with whom you live and purchase and prepare your food.)

Name and age of the child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  I am caring for an incapacitated person. (The person does not need to live with you.)

Name of the person you are caring for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tell us what you do for this person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  I am in a work‐training program.

Name of the program: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hours that you attend the program each week: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Give us proof of your participation in the work‐training program.

[ ]  I go to school at least half‐time.

Name of School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Give us proof that your go to school at least half‐time.

[ ]  I am getting unemployment compensation or have applied for unemployment compensation.

[ ]  I get disability benefits from a government or private source.

Examples of government disability benefits include Social Security disability benefits, Supplemental Security Income (SSI) and disability benefits paid by the US Dept. of Veteran’s Affairs. Examples of private disability benefits include certain pensions, Workers’ Compensation and payments from disability insurance.

What benefit do you get? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Give us proof from the place where you do volunteer work. The proof 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Return this form and any supporting information to:

The DSS ConneCT Scanning Center

PO Box 1320

Manchester CT 06045-1320

Make sure that your client number ID is on every document that you send in.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits.  Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339.  Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the [USDA Program Discrimination Complaint Form](http://www.ocio.usda.gov/sites/default/files/docs/2012/Complain_combined_6_8_12.pdf), (AD-3027), found on the USDA site, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992.  Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture

Office of the Assistant Secretary for Civil Rights

1400 Independence Avenue, SW

Washington, D.C. 20250-9410;

(2)       fax: (202) 690-7442; or

(3)       email: program.intake@usda.gov.

This institution is an equal opportunity provider

NOTE: A SNAP client or applicant may file a civil rights or programmatic complaint with the Federal government at any time within 180 calendar days from the event that is the basis of their complaint.  This may be in addition to any complaint filed at the State level as long as the basis is one of the eight Federally protected bases for SNAP.

Persons who are deaf or hard of hearing and have a TTD/TTY device can contact DSS at

1-800-842-4524. Persons, who are blind or visually impaired, can contact DSS at 1-860-424-5040.