



W-1460  
(Rev 10/24)

# State of Connecticut Department of Social Services

## Request for Exemption from the SNAP Time Limit

Supplemental Nutrition Assistance Program (SNAP) rules limit most adults who are between 18 and 54 years old, and who 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. If we need you to give us proof about your situation, we will ask you.

### 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 proof (examples):

- 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 served in the United States Armed Forces (regardless of the conditions of discharge or release).

Examples of proof you can give us if we ask you for proof:

- DD Form 214, Certificate of Release, or
- Certificate of Release or Discharge from Active Duty, or
- Original Certificate of Discharge, or
- Report of Transfer or Discharge, or
- Military ID card indicating service in the armed forces, or
- Benefit payment or award letter, or
- VA ID Card, or
- Letter from the Dept. Veteran Affairs indicating service in the armed forces, or
- Driver's license indicating veteran status

- I am experiencing homelessness (I am living on the street or in a shelter, or I do not know where I will sleep each night, or I am temporarily living with another person for less than 90 days).

Examples of proof you can give us if we ask you for proof:

- A letter from a social worker stating that you are homeless, or
- A letter from a homeless shelter stating you are living there, or
- A letter from the person you are temporarily living with stating the date you started living with them.

- I am 24 or younger and I was in foster care between my 18<sup>th</sup> and 21<sup>st</sup> birthday.

Examples of proof you can give us if we ask you for proof:

- A letter from DCF or the administering Foster Care Agency, or
- Contact information for your DCF Social Worker or the administering Foster Care Agency

- I am physically or mentally unfit to work 20 hours per week (addiction to drugs or alcohol while not participating in a treatment program and/or chronic homelessness may be indicators of unfitness to work as it relates to the ABAWD work requirement).

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 (examples):

- A letter from your Doctor stating you are pregnant, or
- Medical records stating you are pregnant

- 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.)

We will give you a Medical Report form for you to have completed and returned to us. It must show that you are not able to work at least 20 hours per week because you are needed to care for an incapacitated person.

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 (examples):

- A letter from the program stating the hours you attend the program each week, or
- Your schedule from the program stating the hours you attend the program each week

- I go to school at least half-time.

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

Give us proof (examples):

- A letter from the school you attend stating that you attend at least half time, or
- School schedule showing that you attend you attend at least half time

- I am getting unemployment compensation or have applied for unemployment compensation.

Give us proof (examples):

- A letter from unemployment compensation showing the date you applied, or the amount(s) you receive, or
- Unemployment compensation benefit award letter, or
- Print out of current unemployment compensation benefits

- 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? \_\_\_\_\_

Give us proof (examples):

- Disability benefit award letter, or
- Copy of disability payment, or
- Print out of current disability payment history

- 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, and
- 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**

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, (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](mailto: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.