W-1460
(Rev 11/25)

# State of Connecticut
# Department of Social Services

## Request for Exemption from the SNAP Time Limit

Supplemental Nutrition Assistance Program (SNAP) rules define adults who: (a) are between 18 and 64 years of age, and (b) do not live with children under age 14, as "able-bodied adults without dependents," or "ABAWDs." ABAWDs can only get 3 months of SNAP benefits in a 36-month period, unless they meet work/training/volunteer requirements.

We have determined that you are an ABAWD. To get SNAP benefits for more than 3 months, an ABAWD must work, participate in an employment and training program, participate in a workfare program, and/or volunteer, for a total of at least 80 hours per month.

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 SNAP work requirements. If we need you to give us proof about your situation, we will ask you or you can include proof with this form.

**Section 1:** Your Information

Name: _____

Address:_____

Phone Number: _____ DSS Client ID# _____DSS Case# _____

**Section 2:** Check **all that apply to you** and give us proof.

☐ **I am working at least 80 hours per month or make at least $217.50 per week, including through self-employment.**

Give us proof (examples):

- Last 4 weeks of pay stubs
- A signed and dated letter on your employer's letterhead with your anticipated weekly hours and pay per hour
- Proof of your self-employment

☐ **I am volunteering or doing "community service" work.**

Give us a letter from the place where you volunteer. It 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 member and the date

☐ **I live with a child under 14 years old (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 physically or mentally unable to work 20 hours per week.** (Indicators of individuals being unfit for work include but are not limited to):

- A person suffering from drug or alcohol addiction who is not in a rehabilitation program
- Chronic homelessness (have been continually homeless for at least 1 year or have had at least 4 episodes of homelessness in the last 3 years)
- Mental or physical unfitness to work based on the DSS worker's observation or as verified by a qualified health professional when the unfitness is not obvious
- Receipt of any temporary or permanent disability benefits

Give us proof (examples):

- The Medical Report form we give you to have completed and returned, or
- A letter from a qualified health professional stating that you are physically or mentally unfit to work at least 20 hours per week

Note: A qualified health professional is an individual licensed by the Connecticut Medical Examining Board to provide medical care or other medical services. If questionable, go to https://www.elicense.ct.gov/Lookup/LicenseLookup.aspx to determine if a person is licensed in Connecticut.

☐ **I am in a substance abuse treatment program.**

Name of the program: _____

Give us proof (examples):

- Medical Report form we send you
- A letter from the treatment program confirming your participation in the program, signed and dated by a staff member

☐ **I am pregnant.**

Give us proof (examples):

- A letter from your doctor stating you are pregnant
- Medical records stating you are pregnant

☐ **I am caring for someone who cannot take care of themselves. (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: _____

_____

- Have a doctor, mental health provider, or other medical provider complete and return the Medical Report form that we send you for the person who needs care
- Provide a letter from a doctor, mental health provider, or other medical provider stating you cannot work 20 hours per week because you need to take care of an incapacitated 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
- 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 current letter from the school you attend stating that you attend at least half time
- School schedule showing that you attend at least half time

☐ **I am getting unemployment or have applied for unemployment.**

Give us proof (examples):

- A letter from the Department of Labor showing the date you applied for unemployment compensation
- A letter showing the amount(s) of unemployment compensation you receive
- Unemployment compensation benefit award letter
- Print out of current unemployment compensation benefits
- A letter from the Department of Labor showing you have a pending application for unemployment compensation

☐ **I get disability benefits such as SSI, SSDI, VA benefits, or similar benefits from a private source.**

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 letter
- Copy of disability payment
- Print out of current disability payment history
- Proof of a pending application for disability benefits

☐ **I am a member or descendant of a federally recognized, state-recognized, or terminated Native American tribe.**

Give us proof (examples):

- A Certificate of Degree of Indian Blood (CDIB)
- Card issued by the Bureau of Indian Affairs
- Tribal Citizenship Card
- Letter from a federally or state-recognized tribe verifying membership
- Other documents verifying tribal membership

**Section 3:** Your Signature

Signature _____ Date _____

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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 State or local Agency that administers the program or contact USDA through the Telecommunications Relay Service at 711 (voice and TTY). Additionally, program information may be made available in languages other than English.

To file a program discrimination complaint, complete the USDA Program Discrimination Complaint Form, AD-3027, found online at https://www.usda.gov/oascr/how-to-file-a-program-discrimination-complaint 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, Mail Stop 9410, Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov.

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