

RHODE ISLAND DEPARTMENT OF HUMAN SERVICES

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 www.dhs.ri.gov

If you have an account with www.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: Check **all that apply to you** and give us the requested information.

- 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: _____

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

Name of the person you are caring for _____

What you do for this person:

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

Name of the program: _____

Give us the following verification:

- 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: _____

Give us 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.

Give us 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 www.healthyrhode.ri.gov

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.