Community Partner ABAWD Exemption Request

Dear Community Partner,

Your client, _____, with RIBridges Case # _____, has requested an exemption from required work-related activities associated with their application for/receipt of Supplemental Nutrition Assistance Program (SNAP) benefits.
According to our records, they are:

- Between the ages of 18-64;
- Living in a SNAP household where no one is under age 14;
- Does not have a medically certified disability that prevents them from working;
- Not pregnant;
- Not working or volunteering at least 80 total hours a month;
- Not participating in a SNAP E&T program or WIOA funded program;
- Not an Indian, Urban Indian or California Indian, as defined by law

If you believe the above information to be incorrect, please assist your client with reporting that to DHS.

If the above information is accurate, your client may be exempt from the ABAWD work requirement and able to maintain benefits beyond 3 months, if they are physically, mentally, or emotionally unfit for work.

Your familiarity with the SNAP applicant may help us to determine whether they meet the unfit for work criteria.

- Does your client have multiple weekly medical (including counseling) appointments making it difficult for them to get or maintain employment? Documetnation on official letterhead from health care professional/health center may serve as verification.
  ☐ Yes ☐ No
- Does your client have regular meetings and obligations as part of their engagement with your agency that hinders their ability to get or maintain employment? Documentation on agency letterhead indicating the type and frequency of commitment may serve as verification.
  ☐ Yes ☐ No
- Does your client struggle with any of the following making it difficult for them to get or maintain employment?
  ☐ Making eye contact ☐ Talking to people ☐ Organization of time
  ☐ Access to bathing/hygiene ☐ No safe place to keep belongings

Is there anything you think we should know about your client to help us determine their ability to find and maintain employment?

_____

_____

_____

Under penalty of perjury, I attest that all of the information contained in this form is true. I understand that I am breaking the law if I give false information and can be punished under federal law, state law or both.

Name of person completing this form _____ Date _____

Signature of person completing this form _____Date _____

Agency/Title _____Phone _____

Submit the completed and signed form through the following pathways:

- Mail to RI Department of Human Services, P.O. Box 8709, Cranston, RI 02920-8787;
- Drop off in person or at a Drop Box Office location listed at https://dhs.ri.gov/about-us/dhs-offices
- Log in and upload to your Customer Portal account at https://www.healthyrhode.ri.gov; or
- Access through the HealthyRhode Mobile App in the APP store or Google Play

For questions, call: 1-855-MY-RIDHS (1-855-697-4347)

Note: If your client is applying or recertifying at this time, they may submit this completed and signed form with their DHS application or renewal documents.