

# Group 2: **ABAWDs Not Subject to the Time Limit**

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## **Group 2: ABAWDs Not Subject to the Time Limit**

- Exemptions
- Unfit for work
- Optional Individual exemptions
- Proper notification
- Engaging Partner Organizations and Programs



# Screening for Exemptions

- Under 18 or over 49 years old
- Child in the household
- Pregnant
- Unfit for work
  - homeless
  - other groups as defined by the state
- Caring for an incapacitated person
- Receiving unemployment
- Regular participant in drug or alcohol treatment
- Eligible student



# PA Screening Form



**pennsylvania**  
DEPARTMENT OF HUMAN SERVICES

Name \_\_\_\_\_

Record No. or SSN \_\_\_\_\_

As of March 1, 2016, an Able-Bodied Adult Without Dependents (ABAWD) in your area must be working at least 20 hours per week or be participating in an approved Supplemental Nutrition Assistance Program (SNAP) employment and training component in order to remain eligible for SNAP after receiving three months of benefits, unless they are exempt.

**In an effort to ensure everyone who is eligible keeps their SNAP benefits, please complete the survey below and return it in the enclosed postage paid envelope as soon as possible-preferably within 10 days:**

## Individual and Household Questions - Circle Yes or No:

- Yes No Is anyone in your house under the age of 18?
- Yes No **If yes**, do you purchase and prepare your meals with this person?
- Yes No Are you pregnant?
- Yes No Is your ability to work at least 20 hours a week limited by your physical or mental health?
- Yes No Are you receiving or have you applied for any public or private disability or sick benefits, such as SSI?
- Yes No Are you needed in the home to care for an ill or incapacitated household member?
- Yes No Are you participating in a drug or alcohol treatment program?
- Yes No Are you unable to work because of domestic violence? **Circle Yes if:**
- You or your children will be at risk of being harmed if you work, or
  - It will be more difficult for you to recover from abuse if you work.
- Yes No Are you homeless or facing homelessness?
- Yes No Are you receiving or have you applied for Unemployment Compensation?
- Yes No Are you expected to return to work within the next 60 days?
- Yes No Are you a migrant or seasonal farmworker returning to work within 30 days?
- Yes No Are you enrolled in school or training at least half time?

## Employment, Training, and Community Service Questions - Circle Yes or No:

- Yes No Are you working?  
**If yes**, where? \_\_\_\_\_  
How many hours a week? \_\_\_\_\_
- Yes No Are you taking classes to learn English?  
**If no**, are you interested in taking free classes? \_\_\_\_\_
- Yes No Are you in school or a training program?  
**If yes**, what are you studying? \_\_\_\_\_  
How many hours a week? \_\_\_\_\_
- Yes No Are you interested in going back to school at least 20 hours a week?

# MA Exemption Form

Massachusetts Department of Transitional Assistance  
Supplemental Nutrition Assistance Program

**Request for ABAWD  
Work Program Exemption**  
*For people ages 18 to 49*

Give this form to DTA

- By Mail: DTA Document Processing Center, P.O. Box 4406, Taunton, MA 02780-0420
- By fax: (617) 887-8765
- In person at your local DTA office

SNAP rules say that you are limited to 3 months of SNAP benefits 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 DTA. If you have questions or need help, call DTA at (877) 382-2363.

**Section 1:** Client Information

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

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

Phone Number: \_\_\_\_\_ Agency ID 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 physically or mentally unable to work 20 hours per week.

You need to give us a completed SNAP ABAWD Work Requirement Medical Report form or a letter from a medical or mental health provider stating you are not able to work 20 hours per week.

I am in a substance abuse treatment program.

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

You need to give us a completed ABAWD Work Program Requirement Medical Report form or a document that shows your participation in the treatment program.

# Exempt Because Unfit for Work

Medically certified as physically or mentally unfit for work

- Receives temporary or permanent public or private disability benefits;
  - *NOTE: includes all disabled veterans*
- Is obviously unfit as determined by the state agency;
- If not obvious, provides a statement from a:
  - Physician or physician's assistant,
  - Nurse or nurse practitioner,
  - physician's office,
  - psychologist,
  - social worker, or
  - any other medical personnel the state determines appropriate.



# Medically Unfit for Work Form



## ABAWD Time Limit Medical Exemption Form

Dear Medical Provider:

The Supplemental Nutrition Assistance Program (SNAP, formerly the Food Stamp program), limits Able-Bodied Adults without Dependents (ABAWD) to only 3 months of SNAP within 36 months. This rule applies unless the adult is working a minimum of 20 hours per week or is exempt from the time limit because the individual is medically certified as physically or mentally unfit for employment or falls within another exemption. Please help us determine whether your patient meets the exemption due to medical or mental issues and can be exempted from the ABAWD provisions.

Patient's name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

**Patient/participant's authorization:**

I hereby authorize the release of the medical information and/or rehabilitation participation requested to the Pennsylvania Department of Human Services.

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Please answer one or more of the following questions in the box below. Please sign and date this form including your title or position in your agency\*.

1. Is this individual pregnant?

Yes  No If yes, due date? \_\_\_\_/\_\_\_\_/\_\_\_\_

2. Is this individual a participating in drug/alcohol treatment or counseling program; mental health counseling program; or a vocational rehabilitation program?

Yes  No If yes, specify program: \_\_\_\_\_

Is this program ongoing?  Yes  No If no, date program will end: \_\_\_\_/\_\_\_\_/\_\_\_\_

3. Does this patient have a mental and/or physical illness or disability which reduces his or her ability to financially support him or herself?

Yes  No If yes, specify disability: \_\_\_\_\_

Is this condition ongoing?  Yes  No If no, date it is expected to end: \_\_\_\_/\_\_\_\_/\_\_\_\_

I certify that the information provided above is true and accurate.

\_\_\_\_\_  
Name (please print)

\_\_\_\_\_  
Title/profession\*

\_\_\_\_\_  
Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date form signed



# Community Partners can Help

## Health Care Providers:

### You Can Help Low-Income Adults Keep Their SNAP (Food Stamp) Benefits

SNAP benefits (formerly food stamps) allow low-income people to buy the food they need to stay healthy. Many SNAP recipients ages 18 to 49 are at risk of losing their SNAP benefits, starting in May, due to a SNAP rule that went into effect on January 1, 2016. The rule referred to as Able Bodied Adults Without Dependents (ABAWD) limits SNAP eligibility to three months.

**With just a few minutes of your time, you can easily help.** Many of those categorized as ABAWDs are not “able-bodied” due to a physical or mental condition that reduces their ability to work.

## Frequently Asked Questions

How disabled do my patients have to be to be exempt from the rule that reduces their ability to work?

People are exempt from the rule that reduces their ability to work if they are disabled or have a physical or mental condition that reduces their ability to work.

Some patients have impairments that allow them to work for a limited number of hours per week. This standard of work does not require a diagnosis or a specific work schedule.



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CeltiCare Health > Newsroom > Provider News > SNAP benefits (formerly food stamps) UPDATE

## Provider News

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### SNAP benefits (formerly food stamps) UPDATE

Posted 22 December 2015 by supaul & filed under Newsroom, Provider News.

SNAP benefits (formerly food stamps) allow low-income people to buy the food they need to stay healthy. Many patients and CeltiCare Health members (single adults ages 18-50) are considered Able-bodied Adults Without Dependents (ABAWDs). **They are at risk of losing their SNAP benefits** (food stamps) because of a reinstated federal rule that goes into effect on January 1, 2016. The rule limits SNAP benefits to 3 months in a 3 year period – unless your patient meets an exemption or certain work rules.

**With just a few minutes of your time, we can easily help.** Many ABAWDs may be homeless, lacking regular health care, disabled or unable to work. If you are working with a patient who fits this description, you can easily help him or her. To learn how, [click here for more information.](#)



Due to a reinstated federal rule that became effective January 1, 2016, all states' nutritional assistance programs (SNAP benefits formerly called food stamps) have been limited to three months in a three year period for able bodied adults, ages 18 through 49, without dependents (ABAWD). This includes non-disabled low income people who are not pregnant or living in a household with minor children. About 28,000 very low income individuals in Massachusetts could be impacted.

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# Community Screening Tool

## Request Form for Food Supplement Extension

*(For people between the ages of 18 to 50)*

You can use this form if you are losing or have lost your Food Supplement benefits because of the 3-month time limit.

- You must be between the ages of 18-50 to use this form. You must fit into one of the groups below to keep getting benefits.

**Section 1:** Please provide your information below.

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

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

Phone Number: \_\_\_\_\_

Social Security Number or DHHS ID Number: \_\_\_\_\_

Signature \_\_\_\_\_

Date Mailing This In \_\_\_\_\_

**Section 2:**

Check all that apply to you

1.  I am working at least 20 hours per week on average.  
  
\*Attach last 4 pay stubs or a signed and dated letter on employer's letterhead with anticipated weekly hours and pay per hour.
2.  I am physically or mentally unable to work 30 hours or more per week.  
  
\*Attach Medical Exemption form or letter from medical or behavioral health professional explaining why you are not able to work 30 or more hours per week.
3.  I am taking care of a child under age 18 who lives with me.  
  
\* Please explain who you are providing care for and what you do.  
\_\_\_\_\_  
\_\_\_\_\_

4.  I am caring for an adult with a disability. (The adult does not need to live with you.)

\*Please tell us who you are caring for and what you do for the person.

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

5.  I am pregnant.

\*It would help if you could give us a doctor's note or other document showing that you are pregnant.

6.  I am in a work training program.

\*Please tell us what training program you are in and the hours that you attend the program each week.

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

7.  I am in a substance abuse program.

\*What is the name of the program you are in and when did it start?

\_\_\_\_\_

8.  I go to school at least half (½) time.

\* What school do you go to and how many hours do you go to school a week?

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

9.  I am getting unemployment benefits or I have applied for unemployment.

10.  I get disability benefits from a private source or through the government, such as Social Security, SSI, Veterans, Maine State Disability, etc.

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

# Exemption for Chronically Homeless

*A chronically homeless individual who is living on the street may be considered unfit for employment as determined by the state.*

FNS Guidance, November, 2015

State examples:

- An individual who lacks a permanent residence
- An individual who self-certifies they do not have a stable night time residence
- Form for shelter staff





**Give this form to DTA**

- By Mail: DTA Document Processing Center, P.O. Box 4406, Taunton, MA 02780-0420
- By fax: (617) 887-8765
- In person at your local DTA office

# Homeless Exemption Form

## Request for ABAWD Work Program Exemption Supplement For homeless people ages 18 to 49

As a homeless individual, you might be exempt from the ABAWD Work Program requirement. Use this form to tell us about your situation so we can determine if you are exempt. Give the completed form to DTA. If you have questions or need help, call DTA at (877) 382-2363.

### Section 1: Client Information

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

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

Phone Number: \_\_\_\_\_ Agency ID or Last 4 digits of SSN: \_\_\_\_\_

### Section 2: Check the box next to your response to each question below.

**1) Do you have a stable night time residence?**

Yes       No       I prefer not to answer

**2) Do you have a high school diploma or equivalency (GED or HiSet)?**

Yes       No       I prefer not to answer

**3) During the last 3 years, have you been steadily employed for at least 6 months or a full-time student for at least 6 months?**

Yes       No       I prefer not to answer

**4) Do you regularly access health care that you need, such as dental care, psychiatric care, and treatment for an ongoing illness?**

Yes       No       I prefer not to answer

**5) Have you been hospitalized during the last 6 months?**

Yes       No       I prefer not to answer

### Section 3: Signature

# Unfit for Work – Example from Mississippi Battling Drug and Alcohol Addiction

An individual battling drug or alcohol addiction is an example of one who may be unfit to work. If the individual is not enrolled in a drug/alcohol treatment program, he/she would not be eligible for a work registration exemption, but may be exempt from the ABAWD time-limit and not referable to E & T. Agency staff may have knowledge that such an individual would be unfit for work or would not be accepted into a workfare program because of addiction issues.



# Optional Individual Exemptions

- Exemptions equal to 15 percent of the State's ABAWD caseload subject to the time limit.
- One exemption equals one individual for one month
- Can be used to:
  - Exempt individuals in hard-hit or hard-to-serve areas
  - Reward work effort
  - Address barriers to work
  - Apply to prior months
- Must track and correctly code



## Discussion

- Best options to identify exempt individuals?
- Best time to assess them?
- How might your county organize the exemption process (centralized unit? All workers?)
- Who are potential partners?
- Can other programs help, i.e. Medi-Cal?
- What will be difficult about finding exempt individuals?

