DC | DEPARTMENT of HUMAN SERVICES

SNAP Work Requirements Screening Form

DHS Only

Date Received: _____

SSR Name: _____

Household members between the ages of 16 and 59 might be exempt (excused) from the District of Columbia Supplemental Nutrition Assistance Program (SNAP) general work requirements (GWR) and household members between the ages of 18 and 64 might be excused from the SNAP Able-Bodied Adults Without Dependents (ABAWD) work requirements, if they are facing barriers that would make it difficult to maintain a job. Each household member between the ages of 16 and 64 should complete and sign this form so we can determine if the member is exempt (excused) from GWR and/or ABAWD work requirements.

How to Submit: Please return the completed and signed form to the DHS Economic Security Administration (ESA) using one of the following methods.

Online	Mail	Drop-Off at Service Center	Fax
Complete Online! Scan to complete on Districtdirect.dc.gov or Scan to complete on **District Direct Mobile App** *iPhone & Android Compatible*	District of Columbia Department of Human Services Economic Security Administration Case Record Management Unit P.O. Box 91560 Washington, DC 20090	**Anacostia** 2100 Martin Luther King Avenue, SE **Congress Heights** 4049 South Capitol Street, SW **Fort Davis** 3851 Alabama Avenue, SE **H Street** 645 H Street, NE **Taylor Street** 1207 Taylor Street, NW	202-671-4400

SECTION 1 - YOUR INFORMATION

Full Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Case Number: _____

Note: Your answers may require verification (proof). Your caseworker will let you know what is needed.

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SECTION 2 - BENEFIT INFORMATION

A. ABAWD - New Applicants / Household Members Only

1	In the last 3 years, were you subject to the ABAWD time limit in another state?	☐ Yes ☐ No ☐ I don't know
	If **YES** or 'I don't know,' did you use any of your countable months in another state?	☐ Yes ☐ No ☐ I don't know
	If **YES** or 'I don't know,' list the State(s) where you received SNAP benefits:	

*If **YES**, provide a copy of any letter from the State documenting the month(s) you used.*

2	Do you identify as any of the following?	☐ Indian or Urban Indian ☐ Californian Indian ☐ No ☐ I prefer not to answer

B. Chronic Homelessness

1	Are you homeless and staying somewhere not meant for living or in a shelter?	☐ Yes ☐ No ☐ I prefer not to answer
2	If **YES**, have you been continuously homeless for 1 year or 4 separate times in the last 3 years?	☐ Yes ☐ No ☐ I prefer not to answer
3	If **YES**, Do you have any chronic health problems (i.e. trouble with drugs, mental illness)?	☐ Yes ☐ No ☐ I prefer not to answer

*If **YES** to all questions above (Questions 1-3), you may meet the District of Columbia's definition of chronic homelessness for DC SNAP work requirement exemption purposes.*

C. Barriers to Employment

1	Do you have any other barriers to employment? *Select all that apply to you*	
	☐ I have not been regularly employed or a fulltime student for more than 6 months during the past 3 years.	☐ Hospitalized in the last 6 Months.
	☐ I do not have regular access to needed healthcare (i.e. Dental, medical, psychiatric, and/or mental treatment for an ongoing illness).	☐ I prefer not to answer.

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D. Drug or Alcohol Addiction

1	Do you regularly attend Alcoholics Anonymous, Narcotics Anonymous, or other substance use anonymous meetings?	☐ Yes ☐ No ☐ I prefer not to answer
2	Do you regularly attend substance, drug use, or alcohol treatment program(s)?	☐ Yes ☐ No ☐ I prefer not to answer
3	Are you regularly receiving on-going services from a substance use disorder (SUD) provider in the District or Recovery Support Services (RSS)?	☐ Yes ☐ No ☐ I prefer not to answer
4	Are you on a waiting list to participate in a drug or alcohol treatment program?	☐ Yes ☐ No ☐ I prefer not to answer
5	Do you depend on drugs and/or alcohol to maintain day-to-day functioning?	☐ Yes ☐ No ☐ I prefer not to answer

*If **YES** to at least one of Questions 2-5, a completed SNAP Work Requirements Medical Report Form or other documentary evidence must be submitted.*

E. Caretaker

1	Do you care for a child under age 6 (child does not need to live with you)?	☐ Yes, child's name _____ ☐ No ☐ I prefer not to answer
2	Do you care for an incapacitated person or a person who cannot care for themselves (incapacitated person does not need to live with you)?	☐ Yes, Person's name _____ ☐ No ☐ I prefer not to answer
3	Are you responsible for a child under 14 in your household?	☐ Yes ☐ No ☐ I prefer not to answer

F. Unemployment

1	Have you applied for or are you receiving unemployment benefits (you must be following all required work registration, job search, and reporting rules)?	☐ Yes, applied ☐ Yes, receiving ☐ No ☐ I prefer not to answer

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G. Medical

1	Do you have a medical illness, disability, or condition preventing you from working 20 hours per week? *This could include but is not limited to physical or mental health issues resulting from experience with domestic violence or other traumatic experiences.*	
	☐ Yes, temporary ☐ Yes, permanent ☐ No ☐ I prefer not to answer	
2	Are you receiving mental health counseling services?	☐ Yes ☐ No ☐ I prefer not to answer
3	Select any of the following disability benefits that you are currently receiving:	
	☐ Applied for Social Security Disability Insurance or Supplemental Security Income (SSDI/SSI)	☐ Receiving Social Security Disability Insurance or Supplemental Security Income (SSDI/SSI)
	☐ Veteran's Disability Compensation (any rating)	☐ Short-term Disability Insurance
	☐ Interim Disability Assistance (or on waitlist)	☐ Workmen's Compensation
	☐ Other Disability Benefits	
4	Are you in a Vocational Rehabilitation program or getting Vocational Rehabilitation services from the District or the Department of Veterans Affairs (this includes being in a program even if you are not receiving services)?	☐ Yes ☐ No ☐ I prefer not to answer
5	Are you pregnant?	☐ Yes, estimated due date: _____ ☐ No ☐ I prefer not to answer

*If **YES** to at least one of Questions 1-4, a completed SNAP Work Requirements Medical Report Form or other documentary evidence must be submitted.*

H. Education, Employment, Training Programs

1	Are you participating in any programs to improve your employment skills?	☐ Yes ☐ No ☐ I prefer not to answer
2	Are you participating in a job support program at a Refugee Service Center?	☐ Yes ☐ No ☐ I prefer not to answer
3	Are you self-employed, volunteering, or doing unpaid work that is not part of SNAP Employment & Training (E&T) or the SNAP Volunteer Program (workfare)?	☐ Yes ☐ No ☐ I prefer not to answer

*If **YES** to Questions 1-3, complete a SNAP Verification of Employment, Qualifying Work Activity*

Form or provide proof and submit it to DHS.

4	Are you a student enrolled at least half-time?	☐ Yes ☐ No ☐ I prefer not to answer

*If **YES**, you must provide school verification of your half-time status.*

5	Are you interested in participating in SNAP Employment & Training (E&T) or the SNAP Volunteer (workfare) Programs?	☐ Yes ☐ No ☐ I prefer not to answer

I. Good Cause

If you were unable to complete your work hours or work plan for reasons outside your control, report what prevented you from completing the required activities. Include any other reasons you were unable to work.

Personal illness	☐ Yes	☐ No	☐ Prefer not to answer
Illness of a household member requiring customer to provide care	☐ Yes	☐ No	☐ Prefer not to answer
Illness of a relative requiring presence of customer	☐ Yes	☐ No	☐ Prefer not to answer
A household emergency	☐ Yes	☐ No	☐ Prefer not to answer
A declaration of disaster	☐ Yes	☐ No	☐ Prefer not to answer
Lack of adequate childcare for children who are at least age 6 but under age 12	☐ Yes	☐ No	☐ Prefer not to answer
Lack of available transportation	☐ Yes	☐ No	☐ Prefer not to answer
A household emergency such as a death in the family	☐ Yes	☐ No	☐ Prefer not to answer
The job meets the definition of unsuitable employment	☐ Yes	☐ No	☐ Prefer not to answer
Other (not listed)			

SECTION 3 - CERTIFICATION

I hereby certify the above information is true and accurat

Signature: _____

Case #: _____ Date: ___/_____ /_____

*To access the **SNAP Work Requirements Medical Report Form** or the **SNAP Verification of Employment, Qualifying Work Activity Form**, scan here:*