



Massachusetts Department of Transitional Assistance  
 Supplemental Nutrition Assistance Program  
**ABAWD Work Program Participation Report**

- Give this form to DTA
- By Mail: DTA Document Processing Center, P.O. Box 4406, Taunton, MA 02780-0420
  - By fax: (617) 887-8765
  - Upload to the DTA Connect App

**Part 1: TO BE COMPLETED BY DTA STAFF**

Client Name:		Agency ID Number:		Date:	
Street Address:		City/Town, State and Zip			

You must meet the Able Bodied Adults without Dependents (ABAWD) Work Program requirement. Based on information known to DTA, you are not exempt and are not working or enrolled in an approved employment and training program 20 hours per week. To keep getting SNAP benefits, you must volunteer at a non-profit organization. To make sure that a community service site you choose meets the requirement, or for referral to an approved site, call the **SNAP Work Requirements Line at 1-888-483-0255**.

**Participation month/year:** \_\_\_\_\_

You may use this form to prove the number of hours that you volunteer in volunteer during the participation month. The number of hours that you must volunteer is determined by dividing your monthly SNAP benefit by 10. For help figuring out how many hours you must volunteer, or if you think you have a good reason for not volunteering, call the **DTA Assistance Line at (877) 382-2363**.

To prove that you have completed your volunteer hours:

- 1) Have a staff person from the Community Service site complete the section on the back of this page.
- 2) Return the completed form to DTA no later than the 5<sup>th</sup> day of \_\_\_\_\_  
 Participation Month + 1, 20\_\_\_\_

**Important:** After not meeting the work requirement 2 or more times you may not receive your SNAP benefits again until you show that you have met the ABAWD Work Program requirement each month or become exempt.

**Part 2: TO BE COMPLETED BY STAFF AT COMMUNITY SERVICE SITE**

<b>Client Name:</b>		<b>APID/SSN:</b>
<b>Address:</b>		

The above named person volunteered at this organization for a total of \_\_\_\_\_ hours during the month of: \_\_\_\_\_ (month and year).

\_\_\_\_\_  
**Name of Non-Profit Organization**

\_\_\_\_\_  
**Address of Non-Profit Organization**

\_\_\_\_\_  
**Phone Number of Non-Profit Organization**

\_\_\_\_\_  
**Printed Name of Staff Person**

\_\_\_\_\_  
**Title of Staff Person**

\_\_\_\_\_  
**Signature of Community Service Site Staff Person**

\_\_\_\_/\_\_\_\_/\_\_\_\_  
**Date**

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This institution is an equal opportunity provider.