**ABLE-BODIED ADULTS WITHOUT DEPENDENTS (ABAWD) WAIVER REQUEST**

This is the public burden statement necessary for all instruments: Public reporting burden for this collection of information varies from 4 hours to 35 hours per response depending on the type of request, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: U.S. Department of Agriculture, Food and Nutrition Services, Office of Policy Support, 1320 Braddock Place, 5th Floor, Alexandria, VA 22314 ATTN: PRA (0584-0479\*). Do not return the completed form to this address.

1. **Type of request:**
2. **Statutory citation:** Section 6(o) of the Food and Nutrition Act of 2008, as amended
3. **Regulatory citation:** 7 CFR 273.24
4. **State:**
5. **Region:**
6. **Regulatory requirements:** Section 6(o) of the Food and Nutrition Act of 2008, as amended, provides that no able-bodied adult without dependents (ABAWD) shall be eligible to participate in the Supplemental Nutrition Assistance Program (SNAP) as a member of any household if the individual received program benefits for more than 3 months during any 3-year period in which the individual was subject to but did not comply with the ABAWD work requirement. Section 6(o) also provides that, upon the request of the State agency, the Secretary may waive the applicability of the 3-month ABAWD time limit for any group of individuals in the State if the Secretary makes a determination that the area in which the individuals reside has an unemployment rate of over 10 percent or does not have a sufficient number of jobs to provide employment for the individuals.
7. **Description of alternative procedures:**
8. **Justification for request:**
9. **Anticipated impact on households and State agency operations:**
10. **Caseload information, including percent, characteristics, and quality control error rate for affection portion (if applicable):**
11. **Anticipated implementation date and time period for which waiver is needed:**
12. **Proposed quality control review procedures:**
13. **Name, title, email, and signature of requesting official:**

**Name:**

**Title:**

**Email:**

**Signature:**

1. **Date of request:**
2. **State agency staff contact:**

**Name:**

**Title:**

**Email:**

1. **Regional Office contact person (*to be completed by FNS regional office*):**