

**Louisiana Department of Children and Family Services
Supplemental Nutrition Assistance Program**

DCFS Document Processing Center
P. O. Box 260031
Baton Rouge, LA 70826-9918
Fax (225) 663-3164

Date: _____
Case Name: _____
CID: _____
Worker #: _____
ABAWD Name: _____

Verification of Able-Bodied Adult Without Dependents (ABAWD) Volunteer Hours

- Please confirm the number of hours the ABAWD listed above volunteers or will volunteer. The ABAWD volunteers or will volunteer at least _____ hours per month beginning _____.
- Please enter the number of volunteer hours that the ABAWD listed above volunteered during the last two months on the table below.
- We are reviewing the past participation of the ABAWD listed above. Please enter the exact number of hours volunteered each month for the period of _____ through _____ on the table below.

Volunteer Hours:

Year: _____

Month	January	February	March	April	May	June
Total Hours						
Month	July	August	September	October	November	December
Total Hours						

Comments: _____

I attest that the above information is true and correct to the best of my knowledge.

Supervisor's Name (Print)

Supervisor's Signature

Supervisor's Phone Number

Agency/Company Name

Date