Case# _____

DELAWARE HEALTH AND SOCIAL SERVICES

DIVISION OF SOCIAL SERVICES

AFFIDAVIT FOR REPLACEMENT OF EBT FOOD BENEFITS

Name: _____

Address: _____

_____

City, State, Zip Code: _____

Case ID Number: _____

Benefit Number: _____

Benefit Month: _____

Date Loss Reported: _____

Date Affidavit Returned to Office: _____

☐ I am requesting the replacement of $ _____ for food purchased with food benefits, which was destroyed or household misfortune. The food was destroyed on _____ by _____

_____

(Verification of the disaster or misfortune will be required and attached to affidavit before replacement.)

☐ I am requesting the replacement of $ _____ in food benefits which were not authorized for use by anyone outside of my household. The benefits were used after I reported the loss to the Customer Service Unit for e-Funds and before my account was frozen. **(Benefits used before the loss was reported to the Delaware EBT Card Customer Service Number 1-800-526-9099 will not be replaced. DSS will verify the time and date of the report made to the customer service number and the time and date of the usage of benefits to determine whether or not benefits will be replaced.)**

☐ Request for other reasons(s). Be specific: _____

_____

(Must be approved by the area Operations Administrator before sending to Payments/DMS.)

CAREFULLY READ THE FOLLOWING STATEMENTS AND SIGN

- I hereby certify under penalty of perjury and/or fraud that my food benefit household has had its food purchased with food benefits destroyed in a household disaster or misfortune or the benefits were used by a person not authorized to use my household's food benefits after I reported the loss to the e-Funds Customer Service Unit.
- I understand that if I intentionally misrepresent the fact I could be prosecuted in a court or referred for an Administrative Disqualification Hearing. If found guilty, I will not be able to get food benefits for one year for the first violation, two years for the second violation, and permanently for the third violation. I understand I can also be charged with perjury for a false claim, fined, or sent to jail by a court.
- I understand that this affidavit must be signed and returned to the Food Supplement Program Office within ten (10) calendar days of the date of the report shown above, or my food benefits will not be replaced.
- I understand that if I do not agree with the action taken on my case, I can request a fair hearing orally or in writing.

Signature:_____ Date:_____

(Household member or Authorized Representative)

Signature:_____ Date:_____

(DSS Primary Case Manager or Social Worker)

DSS / DMS PAYMENTS OFFICE ONLY

Replacement issued on:_____ For Benefit Month:_____ Amount Issued:_____

Replacement denied on: _____ Reason:_____ Signature:_____