Reset Form

AFFIDAVIT FOR REPLACEMENT OF SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP) BENEFITS

State Form 40988 (R10 / 4-23)
FAMILY AND SOCIAL SERVICES ADMINISTRATION

Please print.	
Case name	Case number

INSTRUCTIONS TO CLIENTS: If a replacement issuance is being requested you must complete this form (State Form 40988). It should be completed and returned to the Family and Social Services Administration (FSSA) within ten (10) days of the loss.

If you are unable to bring it to the office due to age, handicap, or lack of transportation and you are unable to appoint an authorized representative, State Form 40988 can be mailed to the FSSA Document Center, P.O. Box 1810, Marion, IN 46952 upon completion.

INSTRUCTIONS TO FSSA: The Family Social Services Administration must provide one (1) copy to the participant or authorized representative.

PARTICIPANT AFFIRMATION

I, _____ , residing at: _____ ,
Full name of client *Household address (number and street, city, state, and ZIP code)*

hereby state that due to a household misfortune or natural disaster, my food purchased with my SNAP benefits was destroyed. I do understand that a household misfortune is a situation which my household had no control over such as weather-related issues or power outages. Appliance malfunction or human error is not considered a household misfortune.

Telephone number where you can be reached	Date the misfortune / disaster occurred *(month, day, year)*	Estimated value of food lost
( )		

Description of the misfortune / disaster (for loss due to power outage: only the value of lost frozen/refrigerated foods are to be reported)

I request the Family and Social Services Administration/Division of Family Resources to issue replacement SNAP benefits. I understand that the amount of replacement benefits for which I am eligible will be determined by the date of loss, the amount of SNAP benefits used and cannot exceed my monthly benefit already received.

AFFIDAVIT AND SIGNATURE

I affirm that the replacement of my SNAP benefit loss is due to a misfortune / disaster and the amount of my loss is my best possible estimate. I understand if I knowingly give false or misleading information in order to become eligible for SNAP benefits I may be prosecuted under all applicable state and federal laws.

I do solemnly swear (or affirm) under penalty of perjury that all statements made in the above request are true and correct to the best of my knowledge and belief. *(If participant affirms, the "swear" should be crossed out.)*

Signature of participant or authorized representative	Date *(month, day, year)*

Witness *(if signature is by "X")*

Address of witness *(number and street, city, state, and ZIP code)*

FOR FSSA USE ONLY

☐ Amount of replacement allotment: _____

☐ Collateral contact made *(Explain in comments. Also include name of person contacted.)*

☐ Benefits not replaced – *Reason*: _____

☐ Amount of SNAP EBT expenditures for assistance group since last monthly allotment:

Comments

DFR Staff Signature

Family and Social Services Administration
Document Center
P.O. Box 1810
Marion, IN 46952
Fax (800) 403-0864