WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

REQUEST FOR REPLACEMENT/SUPPLEMENT OF FOOD PURCHASED WITH SNAP BENEFITS

I am requesting replacement/supplement of the food I bought with SNAP benefits that was destroyed in a household misfortune/disaster on

(Date) ____________________ The amount destroyed was ___________________

Benefit(s) Requested: ________ Replacement Benefits
________ Supplemental Benefits

How was the food destroyed? Please explain:

____

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PLEASE READ THE FOLLOWING BEFORE SIGNING THIS FORM. YOUR SIGNATURE MEANS THAT YOU UNDERSTAND YOUR RIGHTS AND RESPONSIBILITIES AND THAT THE INFORMATION ON THIS FORM IS CORRECT. IF YOU HAVE QUESTIONS, PLEASE ASK YOUR WORKER TO EXPLAIN WHAT YOU DO NOT UNDERSTAND BEFORE YOU SIGN.

I understand the penalties for knowingly giving wrong information. These penalties include repayment of the amount unlawfully received, not being able to receive SNAP for a period of time, and a charge of perjury for a false claim.

I understand that this form must be filled out, signed and returned to the Department with 10 days of the date I reported the loss to the Department. If this is not done, I understand the Department will not replace my destroyed food purchased with SNAP.

I understand that all replacements will be issued into my EBT account.

For disaster supplemental benefits, I understand if my household received the maximum SNAP benefit amount, I am not eligible for D-SNAP supplemental benefits.

_________________________________ ______________________
(SIGNATURE) (DATE)

PLEASE PRINT THE INFORMATION BELOW

NAME: ____________________________ SOCIAL SECURITY NUMBER: ________________________

ADDRESS: ____

ADDRESS: ____________________________ PHONE NUMBER: ________________

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