MDHS Lost Benefit Attestation Form

Head Of Household Name:
Last four (4) digits of Social Security Number:
SNAP Case Number:
Street Address:
Phone Number:
Date of Discovery of Theft:

I, _____, attest that I am the head of household listed above or am an authorized representative on the SNAP case listed above and wish to request replacement SNAP benefits in the amounts listed below to cover the cost of benefits lost due to theft due to card skimming, card cloning, or other similar fraudulent methods (i.e. electronic benefit theft).

Please list the theft transaction details below. You must provide the date of the transaction and the exact amount of the transaction.

Date of Transaction	Amount of Transaction

Describe the loss or theft of benefits:

Was your SNAP/EBT card in your possession at the time of the benefit theft reported above?
◯YES
◯NO (if no, please explain)_____

Verification of the loss is required before any benefits can be replaced. MDHS will validate claims of benefit theft though EBT processor data, statements from customers, retailer data, identified skimming devices**,** or other similar information.

Signature required on the next page.

PLEASE READ THE STATEMENTS BELOW BEFORE SIGNING THIS FORM

YOUR SIGNATURE IS YOUR ATTESTATION OF LOSS

I understand that reports of electronic benefit theft must be reported within 30 calendar days of the discovery of the theft.

I understand that replacement benefits due to theft cannot exceed the amount of two months of SNAP benefits or the amount of my actual reported loss, whichever is less.

I understand that benefits lost due to theft cannot be replaced more than two times in a Federal Fiscal year (October 1 – September 30).

I understand that benefit replacements for theft can only be claimed from **October 1, 2022** through **September 30, 2024**. Benefits stolen through card skimming, card cloning, and similar fraudulent methods between **October 1, 2022** and **September 30, 2024,** are eligible for replacement. Claims must meet the state's timeliness criteria.

I understand that I will be subject to penalties if I misrepresent the facts including, but not limited to, a charge of perjury for a false claim. Providing false information in an attempt to gain replacement benefits is considered an Intentional Program Violation (IPV).

I understand that I have the right to a Fair Hearing if I disagree with the decision to replace benefits made by MDHS.

_____ _____

Client Signature Date