REPLACEMENT OR SUPPLEMENT AFFIDAVIT/AUTHORIZATION (CF 303)

Instructions: In Part A check which box(es) apply to you, sign and return this form within 10 days of your reported loss or no replacement can be made.

CURRENT HOUSEHOLD INFORMATION

Name: ____________________

Address: ____________________

____

PART A - HOUSEHOLD AFFIDAVIT

I,____________________,
declare that the household:

ELECTRONIC BENEFITS TRANSFER (EBT)

☐ EBT card was not received in the mail at the address below and the benefits have been transacted by an unauthorized person:

Mailing Address (Number, Street, P.O. Box)

City State Zip

Home Address (If Different) (Number, Street)

City State Zip

☐ EBT card was reported lost/stolen to the county or to EBT hotline and the county, or the EBT hotline failed to cancel the EBT card and the benefits have been transacted by an unauthorized person.
Reported on ____________ (Date) at __________ (Time)
to____________________

REPLACEMENT

☐ Food destroyed in household misfortune or disaster. What happened and when:

____

SUPPLEMENT

☐ My household experienced one or more adverse effects (loss of income, inaccessible liquid resources, or out of pocket, unreimbursed disaster-related expenses) as a result of the recent disaster that occurred in my county of residence. What happened and when:

____

I declare the above statement is true and correct to the best of my knowledge. I also understand that if I give wrong or incomplete facts I may be disqualified from the CalFresh Program, fined, imprisoned, or all three.

____
Signature Of Responsible Household Member Or Representative Date

COUNTY USE ONLY

Case Name:____________________

Case Number:____________________

Worker:____________________

Date CF 303 Received:____________________

PART B - REPLACEMENT/SUPPLEMENT BENEFITS

☐ APPROVED - EBT Replacement Date __________

☐ APPROVED - Benefit Replacement Date __________

☐ APPROVED - Benefit Replacement Amount $ __________

☐ APPROVED - Disaster Supplement Date __________

☐ APPROVED - Disaster Supplement Amount $__________

☐ DENIED - Reason for Denial (Explain)

____

____
Signature (Person Authorizing Or Denying Request) Date

Rules: These rules may apply and you may review at your welfare office MPP 16-515.