LDSS-2291 (Rev.7/16)

REQUEST FOR REPLACEMENT OF FOOD PURCHASED WITH SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP) BENEFITS

If you are blind or seriously visually impaired and need this application/form in an alternative format, you may request one from your social services district. For additional information regarding the types of formats available, contact your social services district or visit www.otda.ny.gov.

If you are blind or seriously visually impaired, would you like to receive written notices in an alternative format? ____ Yes ____ No

If Yes, check the type of format you would like: ___ Large Print ___ Data CD ___ Audio CD ___ Braille, if you assert that none of the other alternative formats will be equally effective for you.

If you require another accommodation, please contact your social services district.

NEW YORK STATE — OFFICE OF TEMPORARY AND DISABILITY ASSISTANCE

CASE NAME				COUNTY
CASE NUMBER	SSN			DATE OF BIRTH
ADDRESS *(including house and Apt number)*	CITY	STATE	ZIP	PHONE NUMBER

I _____, am the head of household or an adult household member for the above named case and wish to report the following to the agency representative:

My household experienced a loss in the amount of $ _____ of food purchased with Supplemental Nutrition Assistance Program (SNAP) benefits, destroyed as a result of:

☐A power outage
☐A fire
☐A flood
☐Other disaster Describe: _____

_____

Worker Comments: _____

_____

_____

Client Comments: _____

_____

CERTIFICATION

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE STATEMENTS BELOW

I am aware that offering a false instrument for filing as described in Article 175 of the Penal Law is a crime that may have a maximum penalty of four (4) year's imprisonment. If I do so, I will be subject to prosecution under the Civil and Criminal Laws of the United States and New York State and under the regulations of the New York State Office of Temporary and Disability Assistance.

I understand I have a right to a fair hearing to contest the denial or delay of a replacement issuance for my household. Replacements would not be issued pending the fair hearing decision.

I understand that if I do not sign and return this statement to the agency within ten (10) days of the date the loss was reported, the agency will not replace the SNAP benefits.

Signature	**Date**

***Please return this completed form to your local County Social Service Department (SSD) or for NYC residents visit the HRA website for a list of the local center closest to you.**