REPLACEMENT AFFIDAVIT/AUTHORIZATION (DFA 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.

PART A - HOUSEHOLD AFFIDAVIT

I,_____,
declare that the household:

☐ **Did not get in the mail**
- ☐ Authorization to Participate Card (ATP)or other Authorization Document (AD)
- ☐ _____
- ☐ Food Coupon Book(s) for the period of _____

at Mailing Address (Number, Street, P.O. Box)		
City	State	Zip
Home Address (If Different) (Number, Street)		
City	State	Zip

☐ **Got an ATP/AD for the period of** _____.
but it was: ☐ Stolen ☐ Destroyed ☐ Other

☐ **Got Food Coupon Book(s) for the period of** _____.
but they were destroyed. Amount destroyed $ _____.

☐ **Bought food with Food Coupon Book(s)**, but the food was destroyed. Amount destroyed $ _____.

☐ **Other**

What Happened and When:

I also declare that if at any time I get the above described ATP/AD/Food Coupon Book(s), I will return it to:

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 Food Stamp Program, fined, imprisoned, or all three.

SIGNATURE OF RESPONSIBLE HOUSEHOLD MEMBER OR AUTHORIZED REPRESENTATIVE	DATE
☛	

PART B - ACKNOWLEDGEMENT OF RECEIPT (OVER THE COUNTER)

I certify that I got a replacement in the amount of $_____.

☐ ATP/AD ☐ Food Coupon Book(s)

☐ _____

SIGNATURE OF RESPONSIBLE HOUSEHOLD MEMBER OR AUTHORIZED REPRESENTATIVE (WHO GOT REPLACEMENT)	DATE

COUNTY USE ONLY

Case Name:
Case Number:
Worker:
Date DFA 303 Received:

PART C - BENEFIT LOSS

Loss : ☐ ATP/AD ☐ Food Coupon Book(s) ☐ Food

Issuance: ☐ Certified/Registered Mail ☐ Regular Mail ☐ OTC

Date Original Benefit Issued: _____ Date Loss Reported: _____

Type of Loss/Disaster: _____ Value of Food Coupon Allotment: $ _____

Source of Verification: _____

Confirmed that reported loss was not returned on_____ (Date)

PART D - REPLACEMENT AUTHORIZATION

Other replacements received by the household during the last 6 months:

- ☐ Countable (Loss to CWD) $ _____
- ☐ Noncountable (No Loss to CWD) $ _____
- ☐ Determination Pending

☐ APPROVED

	Authorized Replacement Amount
☐ ATP Serial No.: _____	$ _____
☐ Food Coupon	$ _____
☐ _____	$ _____

☐ DENIED
Reason for Denial (Explain):

NAME OF PERSON AUTHORIZING/DENYING REQUEST	DATE