RESET

South Carolina Department of Social Services
Supplemental Nutrition Assistance Program (SNAP)

AFFIDAVIT OF LOSS DUE TO A HOUSEHOLD MISFORTUNE

Case Name:_____ Telephone No.: _____

Case No.:_____ County: _____

I hereby certify, under penalty of perjury and/or fraud that the food purchased with SNAP benefits for the month of _____ were destroyed on _____ as a result of (Please describe how the food was destroyed in the space below):

The value of the food destroyed was $_____.

Receipient's Signature: _____ Date: _____

FOR DSS USE ONLY

◯ Replacement of food authorized: (Attach verification)

Benefit Month and Year:_____ Amount: $_____

◯ Replacement of food denied, reason:

DSS Employee's Signature: _____ Date: _____

DSS Supervisor's Signature: _____ Date: _____

This institution is an equal opportunity provider.

Instructions for DSS Form 1634B

Purpose: The purpose of this form is to inform the Agency when a client reports the loss of SNAP benefits due to a household misfortune.

Instructions:

The DSS Employee or client will input the case name, case number, telephone number of the client and the county in which the client resides in their respective fields.

"The month and year of": The benefit month and year in which the household reports a loss of their SNAP benefits.

"Were destroyed on": The date in which the household reports that a loss of SNAP benefits occurred.

"The value of the food destroyed was": The reported dollar amount of SNAP benefits lost.

Recipient's Signature: Self-explanatory

Date: Recipient inputs the date he/she signs the form.

For DSS Use Only:

Replacement of food authorized: DSS Employee selects this option when it is determined that the household will receive a replacement of SNAP benefits and will attach supporting verification.

Benefit Month and Year: The benefit month and year in which approval occurred for loss of SNAP benefits.

Amount: The dollar amount approved for loss of SNAP benefits.

Replacement of food denied, reason: DSS Employee selects this option when it is determined that the household will not receive a replacement of SNAP benefits and will document an explanation as to the reason why this decision was made.

DSS Employee's Signature: Self-explanatory

Date: DSS Employee inputs the date he/she signs the form.

DSS Supervisor's Signature: Self-explanatory

Date: DSS Supervisor inputs the date he/she signs the form.