GREG GIANFORTE
GOVERNOR

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

CHARLIE T. BRERETON
DIRECTOR

# Replacement Request for EBT – Cloned/Skimmed Supplemental Nutritional Assistance Program (SNAP) Benefits

This form must be used to request the replacement of SNAP or Disaster-SNAP(D-SNAP) benefits that were stolen electronically through Electronic Benefit Transaction (EBT) card skimming, EBT card cloning, or similar fraudulent methods. This Affidavit does not automatically approve or deny your request. Your request will be denied if this Affidavit is not returned to the DPHHS Program Integrity Section, or you do not contact the Program Integrity Unit.

In order to review for the replacement of stolen EBT benefits, the Program Integrity Section requires further information.

## A. Household Information

| Case Name | Case Number | Phone Number |
|---|---|---|
| Residence County | Last 4 digits of EBT Card | Date of Birth |
| Email Address: | | |
| Physical Address (including house and apt number, City & Zip) | | |
| Mailing Address (including house and apt number, City & Zip) | | |

## B. Benefit Loss Information

I, _____, am the head of household or an adult household member for the above-named case and wish to report the following to Montana DPHHS Office of Inspector General (OIG) Program Integrity Section:

Date and Time household became aware of the loss: _____

Method household became aware of the loss: _____

Method household believes the loss occurred: _____

Does the household currently have their EBT card in possession: ☐ YES ☐ NO

If NO, please explain: _____

_____

_____

Did the household have the EBT card in possession when the fraudulent transaction(s) occurred: ☐ YES ☐ NO

If NO, please explain: _____

_____

_____

Did the household report their EBT card lost or stolen: ☐ YES ☐ NO

If NO, please explain:_____

_____

_____

Total amount of SNAP benefits household is requesting to be replaced :_____

List of all fraudulent transactions that were not made by you or your household members (please attach additional sheets if necessary):

| Date of Transaction | Time of Transaction | Amount of Transaction | Retailer Name and Location (address) of Transaction |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Please provide any additional information that can explain the benefit theft you feel is important:

_____

_____

_____

## C. Certification

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

I understand and agree to the following:

- I must complete, submit and sign this form to request the replacement of stolen benefits.
- The information I provided in this request is true and accurate.
- The submission of this request does not guarantee that my benefits will be replaced.
- If I have knowingly misrepresented or have given incorrect information about the facts stated above, I may be charged with an Intentional Program Violation (IPV) and may be subject to civil and criminal penalties including, but not limited to, perjury for a false claim as outlined in 7 CFR 273.16.
- I have a right to a fair hearing to contest the denial or delay of replacement issuance for my household. Replacements will not be issued pending the fair hearing decision.

My answers on this form are correct and complete to the best of my knowledge. I understand that my signature authorizes federal, state and local officials to contact other people or organizations to verify the information I have provided.

| _____ | _____ | _____ |
|---|---|---|
| Printed Name of Household Member | Signature | Date |

Note: This completed and signed affidavit form must be submitted to the DPHHS Program Integrity Section or Office of Public Assistance. This form may be submitted in person, by mail, telephonically, or emailed to HHSQADIPVS@MT.GOV .

D. State Determination

State Use Only

**Replacement Approved**? ☐ **YES** ☐ **NO**
**Replacement Amount(s): $_____ (SNAP) $_____(D-SNAP)**
**Comments:** _____
_____
_____
_____
_____
_____

Legal basis for this action is:
Consolidated Appropriations Act, 2023 (Omnibus), Section 501(b); 7 CFR 273.2; 7 CFR 273.16; 7 CFR 274.6