

Have you lost food because of an emergency?

Do you buy groceries with SNAP? You may be able to get some of your SNAP dollars added back to your EBT card.

WHAT YOU NEED TO KNOW:

- If you receive SNAP benefits and you have lost food due to a household misfortune, you can request replacement SNAP benefits
- The loss can be due to a situation that affects **large areas**, such as a storm or a flood, **or can be specific to a single household**, such as a fire
- Household misfortunes can include:

Storms	Equipment failure (refrigerator or freezer)
Flooding	Extended power outages
Fire	Failure to pay a utility bill

Note: power must be out for 4 hours or more to be eligible for SNAP replacement

WHAT YOU NEED TO DO:

- Fill out and submit a replacement form (on the back side of this flyer) to your local SNAP/HRA office **within 10 days of the loss**. You can do this by mail or in person.
- If you are unable to submit the form within 10 days, call the SNAP/HRA office immediately to verbally report the loss. You will then have 10 days to return the form after you report.
- Your local **Nutrition Outreach and Education Program (NOEP) Coordinator** can help you report the loss and submit the form. They can also help you obtain the form in other languages if necessary. NOEP Coordinators are community partners who can help with any questions you may have about SNAP. It's free and confidential.

To find your local NOEP Coordinator, visit FoodHelpNY.org.

If there is not a NOEP Coordinator in your county, call to find your local SNAP/HRA office:

Outside New York City, dial 800-342-3009

In New York City, dial 311



HUNGER SOLUTIONS
NEW YORK

UNITING POLICIES AND
PROGRAMS TO END HUNGER

FoodHelpNY.org
SummerMealsNY.org
SchoolMealsHubNY.org
AfterschoolMealsNY.org

HungerSolutionsNY.org

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**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 flood
 A fire 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
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*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.

**PETICIÓN DE REEMPLAZO DE ALIMENTOS ADQUIRIDOS CON EL
SUBSIDIO DEL PROGRAMA DE ASISTENCIA NUTRICIONAL SUPLEMENTARIA (SNAP)**

Si usted es una persona ciega o tiene un impedimento visual grave y necesita esta solicitud / formulario en un formato alternativo, lo puede solicitar de su distrito de servicios sociales. Si desea información adicional sobre los tipos de formatos disponibles, comuníquese con su distrito de servicios sociales o ingrese a www.otda.ny.gov.

Si usted es una persona ciega o tiene un impedimento visual grave, ¿Le gustaría recibir notificaciones en un formato alternativo? ___ Sí ___ No

Si contestó «Sí», marque el tipo de formato que desea: ___ Letra Grande ___ CD de Datos ___ CD Audio ___ Braille, si usted determina que ninguno de los otros formatos alternos le serán de igual utilidad a usted.

Si usted necesita otra modificación, favor de comunicarse con su distrito de servicios sociales.

NEW YORK STATE		OFFICE OF TEMPORARY AND DISABILITY ASSISTANCE		
CASO A NOMBRE DE:		CONDADO		
Nº DE CASO	Nº DE SEGURO SOCIAL		FECHA DE NACIMIENTO	
DIRECCIÓN (incluya el Nº de la casa o del apto.)	CIUDAD	ESTADO	CÓDIGO POSTAL	Nº DE TELÉFONO

Yo _____, siendo el jefe del hogar o integrante adulto del hogar correspondiente al caso mencionado arriba, deseo informar lo siguiente al representante de la agencia:

Mi hogar sostuvo una pérdida por el monto de \$ _____ de alimentos comprados con subsidios del Programa de Asistencia Nutricional Suplementaria (SNAP) y los cuales se dañaron debido a:

Una interrupción del servicio eléctrico
 Un incendio

Una inundación
 Otro desastre Describa: _____

Comentarios del trabajador social: _____

Comentarios del cliente: _____

CERTIFICACIÓN

NO FIRME HASTA QUE HAYA LEÍDO Y ENTENDIDO LOS ENUNCIADOS A CONTINUACIÓN

Yo entiendo que el ofrecer un instrumento falso para su registro, tal como lo describe el Artículo 175 de la Ley Penal, es un delito el cual conlleva una pena máxima de cuatro (4) años de prisión. Si lo hago, estaré sujeto a procedimientos judiciales bajo la Leyes Civiles y Penales Estadounidenses y del Estado de Nueva York y según las pautas de la oficina estatal New York State Office of Temporary and Disability Assistance.

Entiendo que tengo el derecho a una audiencia imparcial con el fin de oponerme a la denegación o la demora del remplazo destinado a mi grupo familiar. No se emitirán remplazos mientras se espera por la decisión de la audiencia imparcial.

Entiendo que si no firmo y devuelvo esta declaración a la agencia dentro de diez (10) días contados a partir de la fecha que se informa la pérdida, la agencia no remplazará los subsidios SNAP.

Firma	Fecha
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