

**NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Social Services**

DISASTER SUPPLEMENT AFFIDAVIT

County: _____

FNS Case No.: _____

Date of Application : _____

Issuance Month/Year: _____

Name: _____

Address: _____

Reason for Report and Supplement Action:

I hereby certify under penalty of perjury and/or fraud that my household was living in _____ County, at the time of Hurricane Irene and that my household suffered a loss of wages or damage to my home or self-employment property.

I understand that if I am found guilty of an intentional program violation by giving false information on purpose, I will:

- Not get Food and Nutrition Services for 12 months the first time I am found guilty;
- Not get Food and Nutrition Services for 24 months the second time found guilty; **and**
- Not get Food and Nutrition Services for the rest of my life the third time.

Signature: _____

Date: _____

Witness (if signature is by "x" or other mark): _____

FOR OFFICE USE ONLY

Date Supplement Authorized: _____	Supplement Amount: \$ _____
KEY SUPPLEMENTS WITH CODE "W"	
Worker Signature: _____	Worker Number: _____