

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Social Services
REPLACEMENT/SUPPLEMENT AFFIDAVIT

County: _____
FNS Case No.: _____
Date of Report: _____
Issuance Month/Year: _____

Name: _____
Address: _____

Reason for Report and Replacement Action: _____

- I hereby certify under penalty of perjury and/or fraud that food purchased with my Food and Nutrition Services or SUN Bucks benefits has been destroyed due to a household misfortune. The amount of food purchased with Food and Nutrition Services benefits that was lost in the misfortune is \$ _____. I understand that the maximum replacement amount cannot be more than my Food and Nutrition Services or SUN Bucks unit's benefit amount for one month.
- I hereby certify under penalty of perjury and/or fraud that my Food and Nutrition Services or SUN Bucks benefits were stolen under duress. I have reported this to the appropriate law enforcement agency and a police report has been filed.

Reason for Report and Supplement Action: _____

- I hereby certify under penalty of perjury and/or fraud that I incurred a disaster related expense/damage in the amount of \$ _____. I understand that the supplement will bring my benefits up to the maximum allotment for my household size. Households who have already received the maximum allotment are not eligible for supplements.

This affidavit must be signed and returned to the Food and Nutrition Services Office within ten calendar days of the date of report shown above or your Food and Nutrition Services or SUN Bucks benefits will not be replaced/supplemented. If you **only** receive SUN Bucks benefits, please mail this form to Division of Child and Family Well-being Food and Nutrition Services Section Attn: Sun Bucks
2416 Mail Service Center, Raleigh, North Carolina 27699-2418 or for further instructions call 919-707-5659 or email dcfw.fns.admin@dhhs.nc.gov

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

Signature _____ **Date:** _____

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

FOR OFFICE USE ONLY

Date Replacement/Supplement Authorized: _____ Replacement/Supplement Amount: \$ _____

Workers Signature: _____ Workers Telephone Number: _____