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: ___________________________________

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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 has a disaster related expense other than a loss of food.

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: ________________