Virginia Department of Social Services
Division of Benefit Programs
SNAP EBT Replacement Request and Client Attestation

Complete this form for loss due to theft, card skimming, or similar situation and return it to your local department of social services.

Head Of Household:
Last 4 Digits of Social Security Number:
Street Address:
Phone:
Date Of Discovery of Theft:

I, _____attest that I am a member of the household, or an authorized representative, and wish to request replacement SNAP benefits in the amount of $_____to cover the cost of benefits lost due to theft because of skimming, cloning or other similar fraudulent methods that occurred from, ____,20___through ____,20___.

Describe the loss or theft of benefits:

_____

_____

Verification of the loss is required before any benefits can be replaced. The Local Department of Social Services will validate claims of benefit theft though EBT processor data, statements from customers, retailer data, identified skimming devices**,** or other similar information.

PLEASE READ THE STATEMENTS BELOW BEFORE SIGNING THIS FORM
YOUR SIGNATURE IS YOUR ATTESTATION OF LOSS

☐ I understand that reports of electronic benefit theft must be reported within 30 calendar days of the discovery of theft through skimming, cloning, or other similar fraudulent methods.

☐ I understand that replacement benefits due to theft cannot exceed the amount two months of SNAP benefits or the amount of my actual reported loss, whichever is less.

☐ I understand that I must sign and return this statement within 10 business days of the date I reported the household theft to my Local Department of Social Services, or my benefits cannot be replaced.

☐ I understand that benefits lost due to theft cannot be replaced more than two times in a federal fiscal year (October 1 through September 30 of each year 10/1/22 – 9/30/24).

☐ I understand that benefit replacements for theft can only be claimed from **10/1/2022** through **9/30/2024**.

☐ I understand that I will be subject to penalties if I misrepresent the facts including but not limited to a charge of perjury for a false claim.

☐ I understand that I have the right to a Fair Hearing if I disagree with the decision to replace benefits made by Local Department of Social Services.

_____

Client Signature *Date*