LDSS-2291-CH (Rev.7/16)

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

*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.

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申請補發用輔助營養援助計畫 (SNAP)福利購買的食品

如果您為失明或嚴重視力障礙，需要其他格式的申請材料／表格，可向社會服務區索取。若需有關其他格式的更多詳情，請聯絡社會服務區或使用www.otda.ny.gov。

如果您為失明或嚴重視力障礙，是否希望收取其他格式的書面通知？ _____ 是 _____ 否

如果回答“是”，請勾選您需要的格式：___ 大字版 ___ 資料 CD ___ 音訊 CD ___ 盲文, 如果任何其他格式對您不能同樣有效。

如有特別需求，請與社會服務區聯絡。

紐約州臨時救濟及殘障補助辦公室

CASE NAME			郡縣	
CASE NUMBER	社會安全號			生日
位址（包括房屋或公寓號碼）	城市	州	郵遞區號	電話號碼

本人 _____，為戶主或上述各按姓名人家中的成年家人，向機構代表報告以下情況：

我家遭遇損失數額為 $ _____ 的用輔助營養援助計畫 (SNAP)福利購買的食品損失，損失原因為：

☐停電
☐火災
☐水災
☐其他災情 說明: _____

_____

_____

工作人員評注

_____

_____

客戶評注:

_____

_____

認證

在您閱讀並完全理解聲明以前請勿簽署

我理解，根據刑法第175條所述用虛假申報為犯罪，最高刑罰為四（4）年監禁。如果我這樣做，根據美國及紐約州民事和刑事法律，以及紐約州臨時救濟及殘障補助辦公室規定，可以對我起訴。

我理解我有權要求召開公平聽證會質疑對我家申請補發事宜的拒絕或延誤。等待公平聽證裁決期間不能發放補發。

我明白，在損失申報之日起十（10）日內，如果不簽署並將本聲明寄回機構，機構不會補發SNAP福利。

簽名	**日期**

*請將表格寄會當地社會服務部門(SSD)，紐約市居民可使用 HRA網站找到您家附近的辦事處。