STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF WELFARE AND SUPPORTIVE SERVICES
AFFIDAVIT OF CLAIMANT
Replacement of Stolen EBT Benefit Claim Form

Date: _____

Head of Household Name: _____ Case ID or UPI: _____

Address: _____

When did you discover SNAP EBT benefits had been stolen?	Date: _____
Total amount of stolen SNAP benefits:	$ _____
Are you in possession of your EBT card?	☐ Yes ☐ No
Did you file a police report? (Optional)	☐ Yes ☐ No
Is police report attached? (Optional)	☐ Yes ☐ No

Claimant's statement regarding stolen SNAP EBT benefits:

I understand the following: (1) I must report stolen benefits occurring from skimming, cloning or other similar fraudulent methods within 60 calendar days from the date I discovered my benefits were stolen; (2) Replacement benefits due to theft cannot exceed an amount equal to two months of SNAP benefits or the amount of my actual reported loss, whichever is less; (3) To receive SNAP replacement benefits, DWSS must receive this signed form on or before_____; 10 business days after the date of this notice; (4) I can only receive replacement benefits no more than two times due to theft in a federal fiscal year. A federal fiscal year begins on October 1 and ends on September 30 of the following year; (5) Benefit replacement claims can only be made for thefts that occurred between October 1, 2022, and September 30, 2024.

Please list stolen SNAP EBT benefit transaction dates and amounts:

I, _____ attest that I am a member of the household, or an authorized
(Claimant's Name)
representative, and wish to request replacement of benefits lost due to theft that occurred from skimming, cloning, or other similar fraudulent methods. If I have knowingly given incorrect information about the facts stated above, I may be charged with an Intentional Program Violation (IPV) and may be subject to civil and criminal penalties including, but not limited to, perjury for a false claim. I understand that I may have the right to a fair hearing if I disagree with DWSS' decision concerning my request for replacement benefits.

Signature of Claimant: _____ Date: _____

Official Use Only:		
Was SNAP EBT skimming/cloning verified?		☐ Yes ☐ No
Did claimant report loss within 60 days from the discovery date of stolen benefits?		☐ Yes ☐ No
Has EBT card been replaced since skimming and cloning was reported?		☐ Yes ☐ No
SNAP EBT benefits replacement approved?	☐ Yes ☐ No	If Yes; Amount $_____
If no, reason for denial:		