COLORADO
Department of Human Services

SNAP AFFIDAVIT FOR STOLEN BENEFITS

INSTRUCTIONS FOR RECEIVING REPLACEMENT SNAP BENEFITS

If you think you are a victim of electronic benefit theft of your SNAP benefits:

- Fill out this form completely and return it to your county office
- Change your EBT card Personal Identification Number (PIN) immediately
- Cancel and replace your EBT card as soon as possible either by:
  - going to your local county office, or
  - calling Colorado EBT Customer Service at 1-888-328-2656 (TTY: 1-800-659-2656)
- ****You have 30-days from the date you discovered the theft of your SNAP benefits to complete and submit this Affidavit to your local county office.**
- Please note that S-EBT Benefits are not eligible for replacement

*You **may** get your SNAP benefits replaced if:

- Your card was compromised, skimmed or cloned using electronic equipment by a third-party taking your information without your knowledge
- You were scammed into giving your EBT card number and PIN to an unauthorized third-party that you believed to be the contracted EBT vendor, an approved retailer, or a government entity
- You had your EBT card with you when SNAP benefits were stolen from your EBT account
- You completed this SNAP Affidavit for Stolen Benefits and returned it timely to your local county office******

SNAP **cannot** be replaced if:

- You gave your EBT card number and/or PIN to someone you know, and they stole your SNAP benefits
- You wrote your PIN number on your EBT card
- Your physical EBT card was lost or stolen during the timeframe of the reported theft

I believe my SNAP benefits were stolen due to card skimming, cloning, and similar third-party fraudulent methods. By signing this form, I attest to the following:

My (Cardholder) Name is:	**The Last 4 Digits of My EBT Card Number are:**
My Mailing Address is:	
My Phone Number is:	**My Email Address is:**
1. The date I discovered my SNAP benefits were stolen:	
2. The total amount of benefits SNAP stolen:	
3. Did you have your EBT card with you at all times? ☐ **Yes** ☐ **No. Please explain:**	

4. If you feel there is any additional important information related to this incident, please provide details:

Please list all stolen SNAP transactions below (use additional pages if necessary):

Date of SNAP Transaction	Exact Amount of Transaction	Retailer Name	Retailer Complete Address

CERTIFICATION - Please read carefully before signing below:

I understand the following: (1) I have 30 days from the self-declared date I discovered my SNAP benefits were stolen to request replacement and submit this signed statement; (2) Replacement of stolen SNAP benefits for a household cannot exceed the lesser of the amount of benefits stolen or the amount equal to 2 months of the monthly allotment of the household immediately prior to the date when the benefits were stolen; (3) I can only receive two instances of SNAP replacement benefits in each Federal Fiscal Year (October 1 - September 30); (4) S-EBT Benefits are not eligible for replacement.

If I have knowingly given incorrect information about the facts stated above, I may be charged with an intentional program violation (IPV) for the SNAP Program and may be subject to civil and criminal penalties including, but not limited to, perjury for a false declaration. If I am found to have committed an IPV, I will not be eligible for SNAP benefits for 12 months for the first violation, 24 months for the second violation, and forever for the third violation. I understand that any household member who breaks any of the rules on purpose can also be: barred from SNAP for one year to permanently, fined up to $250,000, imprisoned for up to 20 years, or both; barred from SNAP for an additional 18 months if court-ordered, and subject to prosecution under other applicable Federal and State laws.

Signature of Cardholder	**Date**

This institution is an equal opportunity provider.

SNAP AFFIDAVIT FOR STOLEN BENEFITS (COUNTY/STATE USE ONLY)

PLEASE NOTE THAT THIS AFFIDAVIT WILL NOT BE ACCEPTED FOR REPLACEMENT SNAP BENEFITS WITHOUT THE CARDHOLDER SIGNATURE. ONCE YOU HAVE REVIEWED THE CARDHOLDER AFFIDAVIT, COMPLETE THE COUNTY USE SECTION. **ALL** PAGES OF THIS FORM MUST BE SCANNED AND SENT VIA EMAIL TO THE CDHS EBT TEAM AT CDHS_EBT_POLICY@STATE.CO.US

COUNTY USE ONLY (Upon Receipt of Completed Affidavit)

Date Affidavit Received:	Date Sent to the State, if applicable:
Has the County issued a new card to this Cardholder: ☐ YES ☐ NO**- Please Explain: **Please note that replacement SNAP benefits cannot be reissued to a compromised card	
Has the County provided the Cardholder with EBT education: ☐ YES ☐ NO - Please Explain:	
CBMS Case Number:	

STATE USE ONLY

Date Received from County:	Date Validation Results Sent Back to County:	
Validation Results		
Date of SNAP Theft/Date of Occurrence:		
☐ Approved		☐ Denied - Reason for Denial:
SNAP Benefit Month	**SNAP Benefit Amount**	☐ Untimely ☐ Invalid ☐ Excessive Notes:
	$	
	$	
Total Replacement Amount	**$**	
Determination of Approval Amount		
Explanation, if different from the amount stolen:		

COUNTY USE ONLY (Post Validation County Action Taken)

Approved	**Denied**
Date notice sent to Cardholder:	Date notice sent to Cardholder:
Date Benefits Replaced:	
Total Benefits Replaced:	