

REPLACEMENT AFFIDAVIT/AUTHORIZATION (CF 303)

Instructions: In Part A check which box(es) apply to you, sign and return this form within 10 days of your reported loss or no replacement can be made.

PART A - HOUSEHOLD AFFIDAVIT

I, _____, declare that the household:

- Electronic Benefits Transfer (EBT) card was not received in the mail at the address below and the benefits have been transacted by an unauthorized person:

Mailing Address (Number, Street, P.O. Box)		
City	State	Zip
Home Address (If Different) (Number, Street)		
City	State	Zip

- EBT card was reported lost/stolen to the county or to EBT hotline and the county, or the EBT hotline failed to cancel the EBT card and the benefits have been transacted by an unauthorized person.

Reported on _____ at _____
DATE TIME
 to _____

- Food destroyed in household misfortune or disaster. What happened and when:

I declare the above statement is true and correct to the best of my knowledge. I also understand that if I give wrong or incomplete facts I may be disqualified from the CalFresh Program, fined, imprisoned, or all three.

SIGNATURE OF RESPONSIBLE HOUSEHOLD MEMBER OR REPRESENTATIVE (WHO GOT REPLACEMENT)	DATE
---	------

COUNTY USE ONLY

Case Name:
 Case Number:
 Worker:
 Date CF 303 Received:

PART B - REPLACEMENT BENEFITS

- APPROVED - EBT Replacement Date _____
- EBT: Authorized Replacement Amount \$ _____
- DENIED - Reason for Denial (Explain)

SIGNATURE (PERSON AUTHORIZING OR DENYING REQUEST)	DATE
---	------

PART C - ACKNOWLEDGEMENT OF RECEIPT (OVER THE COUNTER)

RECEIVED BY:	DATE
--------------	------



Rules: These rules may apply and you may review at your welfare office MPP 16-515.