NOTICE OF FORM CHANGE NO. 05-038

DATE: 03-01-2005

TO:
County Welfare Director
Supply Clerk / Forms Coordinator

FROM:
Forms Management Unit
(916) 657-1907

☐ Community Care Licensing District Offices
☐ Private and Public Adoption Agencies
☐ District Attorney
☐ Other

Listed below is information regarding a form change. Only applicable information is shown.

This notice updates your Department of Social Services County Forms Catalog.

FORM NUMBER AND TITLE: DFA 303 (2/05) English and Spanish
Replacement Affidavit/Authorization

ORDER UNIT		ESTIMATED PRICE	INITIAL SUPPLY SENT
MASTER ONLY	☒ Free ☐ Sold		☐ Yes ☒ No
☐ New ☒ Revised	DATE OF FORM: 2/05	REPLACES: 8/02	☐ Obsolete

REQUIRED FORM-
☐ No Change Permitted
REQUIRED FORM-
☒ Substitute Permitted With Prior DSS Approval
☐ Recommended Form

UNLESS OTHERWISE SPECIFIED STOCK MAINTAINED AT:
Department of Social Services Warehouse
P.O. Box 980788
West Sacramento, CA 95798-0788

☐ Other:

FORMS DISPOSITION AND SPECIAL INSTRUCTIONS

DISPOSITION OF OLD SUPPLY
☒ Use until exhausted
☐ Destroy

USE NEW FORM
☐ When supply available in DSS Warehouse
☐ Use new form effective _____

USE FORM IN ACCORDANCE WITH
☐ All County Letter No.
☐ Other (specify)

ADDITIONAL INFORMATION REGARDING FORM CHANGE
Attached is a Reproducible Copy

Print form: 8 1/2 x 11, one sided.

Check on the internet to see if forms are available at www.dss.cahwnet.gov

For camera-ready copies of English and Spanish forms, please call the Forms Management Unit (FMU) at (916) 657-1907, or by electronic mail at: fmudss@dss.ca.gov. Contact Language Services for other languages at (916) 445-6778 or by electronic mail at LTS@dss.ca.gov.

REPLACEMENT AFFIDAVIT/AUTHORIZATION (DFA 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:

☐ **Did not get in the mail**
☐ Electronic Benefits Transfer (EBT) Card

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

☐ **Got an EBT card with Food Stamp Benefits for the period of** _____ .
but it was: ☐ Destroyed ☐ Other

☐ **Bought food with Food Stamp Benefits**, but the food was destroyed. Amount destroyed $ _____.

☐ **Other**

What Happened and When:

I also declare that if at any time I get the above described EBT Card, I will return it to:

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 Food Stamp Program, fined, imprisoned, or all three.

SIGNATURE OF RESPONSIBLE HOUSEHOLD MEMBER OR AUTHORIZED REPRESENTATIVE	DATE
☞	

PART B - ACKNOWLEDGEMENT OF RECEIPT (OVER THE COUNTER)

I certify that I got a replacement in the amount of $_____.
☐ Food Stamp Benefits
☐ _____

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

COUNTY USE ONLY

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

PART C - BENEFIT LOSS

Loss : ☐ EBT Card ☐ Food
Issuance: ☐ Certified/Registered Mail ☐ Regular Mail ☐ OTC
Date Original Benefit Issued: Date Loss Reported:

_____ _____
Type of Loss/Disaster: Value of Food Stamp Benefits:
_____ $ _____
Source of Verification:
_____

Confirmed that reported loss was not returned on _____ (Date)

PART D - REPLACEMENT BENEFITS

Other replacements received by the household during the last 6 months:
☐ Countable (Loss to CWD) $ _____
☐ Noncountable (No Loss to CWD) $ _____
☐ Determination Pending

☐ APPROVED
☐ EBT: Authorized Replacement Amount
_____ $ _____
☐ Food Stamp $ _____
Replacement Benefits
☐ _____ $ _____

☐ DENIED
Reason for Denial (Explain):

NAME OF PERSON AUTHORIZING/DENYING REQUEST	DATE

DECLARACION/AUTORIZACION DE REEMPLAZO (DFA 303)

Instrucciones: En la parte A marque las casillas que aplican al caso de usted, firme y devuelva este formulario antes de que pasen 10 días a partir de la fecha en que reportó su pérdida o no se hará el reemplazo.

PARTE A - DECLARACION JURADA DEL GRUPO PARA FINES DE ESTAMPILLAS PARA COMIDA (GRUPO)

Yo, _____,
declaro que el grupo:

☐ **No recibió en el correo**

☐ La tarjeta de transferencia electrónica de beneficios (EBT)

en la dirección para el correo (número, calle, apartado postal)		
Ciudad	Estado	Código postal
Dirección del hogar (si es diferente) (número, calle)		
Ciudad	Estado	Código postal

☐ **Recibió una tarjeta EBT para los beneficios de estampillas para comida para el período de**_____,
pero fue: ☐ Destruida ☐ Otro

☐ **Compró comida con los beneficios de estampillas para comida**, pero la comida fue dañada. Cantidad dañada $_____.

☐ **Otro**

¿Qué pasó y cuándo?:

También declaro que si en cualquier momento recibo la tarjeta EBT descrita anteriormente, la regresaré a:

Declaro que la declaración anterior es verdadera y correcta según mi leal saber y entender. También entiendo que si doy información errónea o incompleta, es posible que se me descalifique del Programa de Estampillas para Comida, se me imponga una multa, se me encarcele, o que reciba las tres sanciones.

FIRMA DEL MIEMBRO RESPONSABLE DEL GRUPO, O REPRESENTANTE AUTORIZADO ☛	FECHA

PARTE B - ACUSE DE RECIBO (EN PERSONA)

Certifico que recibí un reemplazo por la cantidad de $_____.

☐ Estampillas para comida

☐ _____

FIRMA DEL MIEMBRO RESPONSABLE DEL GRUPO, O REPRESENTANTE AUTORIZADO (QUE RECIBIO EL REEMPLAZO)	FECHA

SOLO PARA USO DEL CONDADO

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

PART C - BENEFIT LOSS

Loss: ☐ EBT Card ☐ Food

Issuance: ☐ Certified/Registered Mail ☐ Regular Mail ☐ OTC

Date Original Benefit Issued: _____ Date Loss Reported: _____

Type of Loss/Disaster: _____ Value of Food Stamp Benefits: $ _____

Source of Verification: _____

Confirmed that reported loss was not returned on _____ (Date)

PART D - REPLACEMENT BENEFITS

Other replacements received by the household during the last 6 months:

☐ Countable (Loss to CWD) $ _____

☐ Noncountable (No Loss to CWD) $ _____

☐ Determination Pending

☐ APPROVED

☐ EBT: _____ Authorized Replacement Amount $ _____

☐ Food Stamp Replacement Benefits $ _____

☐ _____ $ _____

☐ DENIED

Reason for Denial (Explain):

NAME OF PERSON AUTHORIZING/DENYING REQUEST	DATE