NOTICE OF FORM CHANGE NO. 05-059

DATE
04-25-2005

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 (3/05) English and Spanish
Replacement Affidavit/authorization (DFA 303)

ORDER UNIT		ESTIMATED PRICE	INITIAL SUPPLY SENT
MASTER ONLY	☒ Free ☐ Sold		☐ Yes ☒ No
☐ New ☒ Revised	DATE OF FORM: 3/05	REPLACES: 3/00	☐ 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:

☐ 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 ________________ (DATE) at __________ (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 Food Stamp Program, fined, imprisoned, or all three.

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 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.

DECLARACION JURADA/AUTORIZACION DE REEMPLAZO (DFA 303)

Instrucciones: En la parte A marque la casilla(s) que aplica al caso de usted, firme y devuelva este formulario antes de que pasen 10 días a partir de la fecha en que se reportó su pérdida, o no se podrá hacer ningún reemplazo.

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

Yo, ____,
declaro lo siguiente en relación al grupo:

☐ No se recibió en el correo la tarjeta de transferencia electrónica de beneficios (EBT) en la dirección que se menciona a continuación y una persona no autorizada hizo una transacción con respecto a los beneficios:

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

☐ Se reportó que la tarjeta de EBT se perdió/fue robada. Esto fue reportado al condado o a la línea de información de EBT, o a ambos, o la línea de información de EBT no canceló la tarjeta de EBT y una persona no autorizada hizo una transacción con respecto a los beneficios.

Fue reportado en __________________ a la(s) ____________
FECHA HORA

a ____.

☐ Se dañó la comida en una calamidad o desastre que el grupo sufrió. ¿Qué pasó y cuándo?:
____
____
____
____
____
____

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 (QUE RECIBIO EL REEMPLAZO) ☞	FECHA

COUNTY USE ONLY

Case Name:
Case Number:
Worker:
Date DFA 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

Reglas: Es posible que las siguientes reglas apliquen; usted puede revisarlas en la oficina de bienestar público: MPP 16-515