RI DEPARTMENT OF HUMAN SERVICES
Request for Replacement of SNAP/RIW Benefits due to Fraud

Name	Phone Number	Address: Street, City/Town
Case Number		**DHS Office**

INSTRUCTIONS

Please use this form if you are requesting a benefit replacement due to stolen benefits, card skimming or other similar reason. Benefits lost due to theft cannot be replaced more than two (2) times through December 20, 2024, in accordance with the Omnibus 501(b) requirement.

This form must be signed and returned within ten (10) business days of the date the fraud was reported to the RI Department of Human Services or benefits will not be replaced.

Please drop off, or mail our completed form to your local DHS office locations listed at www.dhs.ri.gov, or call the RI DHS Information Line at 1.855.MY.RIDHS (1.855.697.4347).

CERTIFICATION

I, _____, am the head of household or an authorized representative for the above named case and wish to report the following to the Department of Human Services.

My household experienced **SNAP fraud** and $ _____ in **SNAP** benefits was stolen.

NOTE: Replacement benefits due to theft cannot exceed the amount of two (2) months of SNAP benefits or the amount of your actual reported loss, whichever is less.

I first made DHS aware of this **fraud/benefit theft** by *(check one)*:

☐ Completing this Form

☐ Calling _____ on _____
(DHS Staff person, if known)

☐ Other: _____

My SNAP benefits were electronically stolen from my EBT card: ☐ Yes ☐ No

My EBT card was in my possession at the time the fraudulent transaction(s) took place: ☐ Yes ☐ No

My EBT card was not authorized to be used by another person at the time fraudulent transaction(s) took place: ☐ Yes ☐ No

(Optional) Please include below any additional information on the stolen benefit transaction(s), if available, that may be helpful in explaining each report of benefit theft (e.g. retailer name and/or address, date of fraudulent transaction, etc.):

_____

_____

_____

_____

_____

PLEASE READ THE STATEMENTS BELOW BEFORE SIGNING THIS FORM.
YOUR SIGNATURE IS YOUR ATTESTATION OF LOSS.

I understand that reports of electronic benefit theft must be reported within thirty (30) days of the discovery of the theft.

I understand that replacement benefits due to theft cannot exceed the amount two (2) months of SNAP benefits or the amount of my actual reported loss, whichever is less. Cash benefits can be replaced up to the amount of my actual loss.

I understand that I must sign and return this statement within ten (10) business days of the date I reported the household theft to DHS, or my benefits cannot be replaced.

I understand that benefits lost due to theft cannot be replaced more than (2) two times within the period of October 1st through December 20th of the following year.

I understand that claims will be accepted for benefits stolen through December 20, 2024, if they meet the timeliness criteria set forth by DHS.

I understand that I will be subject to penalties if I misrepresent the facts including but not limited to a charge of perjury for a false claim, and that any misrepresentation of theft will constitute an intentional program violation (IPV) which may be subject to disqualification from the program.

I understand that I have the right to a Fair Hearing if I disagree with the decision to replace benefits made by DHS.

_____ _____

Signature **Date**

SNAP-55-A Receipt *(Keep this receipt for your records)*

CASE NAME: _____

DHS STAFF NAME: _____

DHS STAFF SIGNATURE: _____

DHS LOCATION RECEIVED: _____

DATE: _____

Average Monthly SNAP: _____