

**NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Division of Social Services**

**REPLACEMENT AFFIDAVIT**

County: \_\_\_\_\_  
FNS Case No.: \_\_\_\_\_  
Date of Report: \_\_\_\_\_  
Issuance Month/Year: \_\_\_\_\_

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Reason for Report and Replacement Action:

- I hereby certify under penalty of perjury and/or fraud that food purchased with my Food and Nutrition Services benefits has been destroyed due to a household misfortune. The amount of food purchased with Food and Nutrition Services benefits that was lost in the misfortune is \$\_\_\_\_\_. I understand that the maximum replacement amount cannot be more than my Food and Nutrition Services unit's benefit amount for one month.
- I hereby certify under penalty of perjury and/or fraud that my Food and Nutrition Services benefits were stolen under duress. I have reported this to the appropriate law enforcement agency and a police report has been filed.

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This affidavit must be signed and returned to the Food and Nutrition Services Office within ten calendar days of the date of report shown above, or your Food and Nutrition Services benefits will not be replaced.

I understand that if I am found guilty of an intentional program violation by giving false information on purpose, I will:

- Not get Food and Nutrition Services for 12 months the first time I am found guilty;
- Not get Food and Nutrition Services for 24 months the second time found guilty; **and**
- Not get Food and Nutrition Services for the rest of my life the third time.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness (if signature is by "x" or other mark): \_\_\_\_\_

**FOR OFFICE USE ONLY**

Date Replacement Authorized: _____	Replacement Amount: \$ _____
Worker Signature: _____	Worker Number: _____