AFFIDAVIT OF DISASTER LOSS
DISASTER SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM

NAME (HEAD OF HOUSEHOLD): _____

CASE NUMBER: _____

HOUSEHOLD ADDRESS: _____

CITY/TOWN/STATE/ZIP CODE: _____

INDIVIDUAL BENEFIT(S) REQUESTED:

_____ SUPPLEMENTAL BENEFITS

I certify under penalty of perjury that my household experienced one or more adverse effects (loss of income, inaccessible liquid resources, or out of pocket, unreimbursed disaster-related expenses) as a result of the flooding that occurred in my county of residence during the period of May 1, 2017 through May 30, 2017

Client Signature: _____

Date: _____

Please provide collateral contact information in order for the State agency to verify your loss. Depending on the availability of power outage data or flood maps to verify your loss, the State agency may decide collateral contact information is not necessary.

Name of Collateral Contact: _____

Street Address: _____

City, State, Zip Code: _____

Phone: _____

Client signature: _____

Date: _____

Instructions for Return of Affidavit:

Mail To: Food Stamp Unit
PO Box 2030
Jefferson City MO 65109

OR

Fax To: 573 897 9869