MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION

REPLACEMENT REQUEST/AFFIDAVIT FOR FOOD STAMP BENEFITS LOST FROM AN EBT ACCOUNT

THIS FORM IS TO BE USED WHEN:

- AN ELIGIBILITY UNIT REPORTS THE MISSOURI EBT CARD IS LOST, STOLEN, OR NOT RECEIVED, AND FOOD STAMP BENEFITS ARE REMOVED FROM THE EBT ACCOUNT, OR
- AN ELIGIBILITY UNIT REPORTS FOOD STAMP BENEFITS WERE REMOVED FROM THE EBT ACCOUNT THROUGH AN UNAUTHORIZED MANUAL VOUCHER TRANSACTION.

IDENTIFICATION

1. NAME	2. PAY COUNTY	3. DCN	4. SCN

5. CURRENT ADDRESS (STREET OR APT. NO., CITY, STATE, ZIP CODE)

6. VALUE OF BENEFITS LOST $	7. DATE CARD REPORTED AS LOST, STOLEN OR NOT RECEIVED	8. DATE IM-113 COMPLETED

9. CLIENT STATEMENT

10. WORKER STATEMENT

INFORMATION TO THE HOUSEHOLD

1) If this statement is not signed and returned within ten days of the date the loss was reported, no replacement will be made.
2) If the above benefits were used by anyone residing or visiting in your household or by your authorized representative, no replacement will be made.
3) If benefits are lost prior to a report of a lost or stolen Missouri EBT card, unless lost prior to receipt of the card by the household, a replacement will not be made.
4) If someone accesses benefits without permission from the household, a replacement will not be made, unless benefits are accessed after the report of a lost or stolen card.

SIGNATURE SECTION

I hereby certify, under penalty of perjury and/or fraud, that I or someone to my knowledge has not used my Missouri EBT card as defined above. I understand that if the benefits reported as lost were used either by me or by someone to my knowledge and consent, I will be ineligible to continue in the Food Stamp Program and will be liable to prosecution under both Federal and State laws.

DATE	SIGNATURE (ELIGIBILITY UNIT MEMBER/AUTHORIZED REPRESENTATIVE)	
DATE	SIGNATURE (CASEWORKER)	COUNTY OFFICE AREA CODE AND PHONE NUMBER

FOR STATE OFFICE USE

REPLACEMENT DETERMINATION

11. REPLACEMENT DENIED

- ☐ Not signed within ten days of non-receipt or loss report.
- ☐ Original benefit used by EU or authorized representative.
- ☐ Benefits lost prior to report of lost/stolen card, and not lost prior to receipt of card by EU.
- ☐ Report of lost/stolen card not made.
- ☐ Manual voucher completed by member of EU/authorized representative.
- ☐ Other – See remarks

Remarks

12. AMOUNT REQUESTED	13. ORIGINAL AMOUNT AVAILABLE	14. ORIGINAL DATE AVAILABLE	15. ☐ FULL MONTH ☐ PRORATED MONTH	16. DATE IM-113 RECEIVED IN STATE OFFICE

17. AMOUNT OF BENEFITS REPLACED	18. DATE REPLACED	19. FOR MONTH/YEAR	20. ☐ FULL MONTH ☐ PRORATED MONTH	21. REPLACED BY