State of Illinois
Department of Human Services

Request for Replacement of Destroyed Food

Date: _____

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Case Number: _____

Office Name: _____

Office Address: _____

_____

Phone: _____

TTY: _____

Fax: _____

NAME: _____
ADDRESS: _____
ADDRESS: _____
CITY, ST. ZIP _____

Tenemos este aviso en español. Para solicitar avisos en español, por Internet vaya al sitio ABE-MMC o llame al 1-800-843-6154 (TTY 1-866-324-5553 TTY/ Nextalk, 711 TTY Relay).

You can manage your account online at abe.illinois.gov

Section I (To be completed and signed by a SNAP Unit Member or Approved Representative)

☐ I declare that $ _____ in food I purchased with SNAP benefits was destroyed in a household disaster.

I understand that if I falsify this report or misrepresent those facts, I will be subject to prosecution with a possible maximum penalty of $10,000 and/or 5 years in prison.

Date Food Destroyed: _____

Description of Household Disaster: _____

_____

Signature of Participant or Approved Representative: _____ Date: _____

Section II (To Be Completed by the Family Community Resource Center):
If customer reports that food was destroyed, make sure benefits were issued within 30 days prior to the disaster.

Effective Month of SNAP Benefits: _____

Amount of SNAP Benefits Issued: _____

Date SNAP Benefits Issued: _____

Date Loss Reported: _____

Verification of Household Disaster: _____

Replacement Request Approved: _____
Amount (can be no greater than the amount of SNAP benefits issued)

Replacement Request Denied: _____
Reason

Caseworker: _____ Date: _____

Supervisor: _____ Date: _____