



REQUEST FOR REPLACEMENT BENEFITS DUE TO LOSS OF SNAP BENEFITS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM
SFN 270 (6-2023)

<input type="checkbox"/> Loss due to fire, natural disaster or household appliance malfunction		<input type="checkbox"/> SNAP Fraud	
Name			Case Number
Address at Time of Loss		City	State ZIP Code
Current Address		City	State ZIP Code
I reported my EBT card lost or stolen to ebtEDGE <input type="checkbox"/> No <input type="checkbox"/> Yes - Date Reported:		Date of Benefits Loss/Discovery	Amount of Loss/Stolen Benefits
Human Service Zone		Date Reported to Human Service Zone	

List the transactions that were not made by you (attach additional sheets if necessary)

Date of Transaction	Amount of Transaction	Retailer Name	Location (Address) of Transaction

List Here Any Additional Information

PENALTY WARNING

Anyone in your household who intentionally violates any of the following rules may not get Supplemental Nutrition Assistance Program benefits for one year, two years or permanently. They may be fined, jailed or both.

The rules are:

DO NOT give false information or conceal information to receive or continue to receive Supplemental Nutrition Assistance Program benefits.

DO NOT give or sell Supplemental Nutrition Assistance Program benefits to anyone not authorized to use them.

DO NOT use Supplemental Nutrition Assistance Program benefits to purchase unauthorized items such as tobacco or alcohol.

I understand the penalties for concealing or giving false information. My household is in need of immediate Supplemental Nutrition Assistance Program benefits as a result of the loss. I certify, under penalty of perjury, that the information I have given is correct and complete to the best of my knowledge.

I understand that by checking this box and typing my name below, I am signing the Request for Replacement Benefits Due to Loss of SNAP Benefits agree that my electronic signature is the legal equivalent of my handwritten signature.

Client Signature	Date
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You may choose to print this Request for Replacement Benefits Due to Loss of SNAP Benefits and return your signed and dated form to your local human service zone office

OR

Submit by mail to:
Department Of Health and Human Services
Customer Support Center
PO Box 5562
Bismarck ND, 58506

OR FAX: (701)-328-1006

OR Email: applyforhelp@nd.gov

For questions call Customer Support Center at: 1-866-614-6005

Human service zone office locations can be found here: <https://www.hhs.nd.gov/human-service/zones>