



GOVERNMENT OF THE VIRGIN ISLANDS OF THE UNITED STATES
Department of Human Services
DIVISION OF FAMILY ASSISTANCE

Request for replacement SNAP benefits due to a household misfortune

Instructions:

If you lost food that you bought with your SNAP benefits because of a fire, flood, loss of electricity for 4 hours or more, broken refrigerator/freezer, or other disaster, we may be able to replace your SNAP benefits. The most we can replace is **one month of benefits**.

To request replacement:

- You must report the loss within 10 days of the food loss. You can do this by phone or in writing.
- Complete the request form and submit it to the district office within 10 days after you reported the loss of food.
- You may submit the completed request form in person, via USPS mail, or email (see agency's contact information listed below.)
- DHS will attempt to confirm what happened by contacting a third party. If DHS is unable to verify what happened, you will need to submit documentation verifying the loss of food. DHS will issue replacement SNAP benefits if you are eligible.

ST. CROIX, VI Department of Human Services Certification Office 4102 Mars Hill Frederiksted, VI 00840-3376 Ph. (340) 772-7100, Ext. 7159/7192, (340) 772-7120 E-Mail: certoffice.stx@dhs.vi.gov	ST. THOMAS/WATER ISLAND, VI Department of Human Services Certification Office 1303 Hospital Ground, Ste. 1 St. Thomas, VI 00802-6722 Ph. (340) 774-0930 or (340) 774-2399 E-Mail: certoffice.stt@dhs.vi.gov	ST. JOHN, VI Multi-Purpose Building, 300 Enighed and Contant Cruz Bay, St. John Email: certoffice.stt@dhs.vi.gov Phone: 340-776-6334 MAILING: Please use the St. Thomas mailing address
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Non-Discrimination Statement

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/ad-3027.pdf>, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to:

1. **mail:**

Food and Nutrition Service, USDA
1320 Braddock Place, Room 334
Alexandria, VA 22314; or

2. **fax:**

(833) 256-1665 or (202) 690-7442; or

3. **email:**

FNCSIVILRIGHTSCOMPLAINTS@usda.gov

This institution is an equal opportunity provider.

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Case name

Case Number

Home Address

Contact Number

Mailing Address

I lost food bought with my SNAP benefits worth \$ _____ due to a household misfortune that happened on ____/____/____.
month day year

I lost my food on ____/____/____.
month day year

The household misfortune was:

Certification

The information I gave is true to the best of my knowledge. I understand that making a false or misleading statement on this form on purpose could be a crime (perjury) or an Intentional Program Violation (IPV). A person found to have committed an IPV will be ineligible for SNAP benefits for 1 year for the first IPV, 2 years for the second IPV, and permanently for the third IPV.

I understand I have the right to a fair hearing to contest the denial or delay of a replacement issuance for my household. Replacements would not be issued pending the fair hearing decision.

Print Name _____

Signature _____

Date _____

Relation to Household:

- Head of Household
- Household Member
- Authorized Representative