REPLACEMENT OR DISASTER SUPPLEMENT AFFIDAVIT (CF 303)

Instructions: Check the box(es) that apply to your household, then sign and return this form.
Note: This form must be submitted within 10 days of your reported food-loss or your household may not be eligible to receive replacement benefits.

State Hearing: If you think this action is wrong, you can ask for a hearing. The back of this page tells you how. Your benefits may not be changed if you ask for a hearing before this action takes place.

CURRENT HOUSEHOLD INFORMATION

Name: _____
Address: _____
_____
Phone: _____

HOUSEHOLD AFFIDAVIT

I,_____,
declare that the household:

ELECTRONIC BENEFITS TRANSFER (EBT)

☐ EBT card was not received in the mail at the address below and the benefits have been transacted by an unauthorized person:

_____
Mailing Address (Number, Street, P.O. Box)

_____
City State Zip

☐ EBT card was reported lost/stolen to the county or to EBT hotline and the county, or the EBT hotline failed to cancel the EBT card and the benefits have been transacted by an unauthorized person.
Reported on _____ at _____.
Date Time

REPLACEMENT

☐ Food destroyed in household misfortune or disaster. What happened and when:

_____
_____
_____
_____
_____
_____
_____

DISASTER SUPPLEMENT

☐ My household lived or worked in a federally declared disaster area with Individual Assistance (IA) and I have experienced one or more adverse effects as a result of the disaster.

I declare that my statement is true and correct to the best of my knowledge. I also understand that if I give wrong or incomplete facts I may be disqualified from the CalFresh Program, fined, imprisoned, or all three.

_____
Signature Of Responsible Household Member Or Representative Date

COUNTY USE ONLY

Case Name:_____
Case Number:_____
Worker:_____
Date CF 303 Received:_____

REPLACEMENT/DISASTER SUPPLEMENT

☐ APPROVED - EBT Replacement Date _____
☐ APPROVED - Benefit Replacement Date _____
CalFresh Benefit Replacement Amount $_____
CFAP Benefit Replacement Amount $_____
☐ APPROVED - Disaster Supplement Date _____
Disaster Supplement Amount $_____
☐ DENIED - Reason for Denial (Explain)
_____
_____
_____

_____
Signature (Person Authorizing Or Denying Request) Date

Rules: These rules may apply: _____
You may review them at your local county office.

YOUR HEARING RIGHTS

YOUR HEARING RIGHTS (See also PUB 412 at www.cdss.ca.gov/inforesources/state-hearings)

You can ask for a hearing if you disagree with a county/agency action or failure to act. You have **90 days** to do so, starting the day after the date of the notice. After 90 days, you must prove you had a good reason for asking late. You can also ask for a hearing to review your benefits for the past 90 days. If you ask for a hearing before the date of the change, your benefits will continue unchanged. CalFresh will end if you don't recertify when due.

- **Online** at acms.dss.ca.gov Click "Create an account" to have an ACMS account and get documents online; or click "Submit Appeal without Account" to file without an account *OR*
- **Call** toll free (800) 743-8525 (or TDD (800) 952-8349) *OR*
- **Fax** fill out this page/fax to (833) 281-0905 *OR*
- Fill out this page, and deliver it by one of the following:
  - o **In-person:** _____
  - o **Mail to**: CDSS State Hearings Division, PO Box 944243, MS 21-37 Sacramento CA 94244-2430
  - o **Email to**: SHDCSU@DSS.ca.gov

HEARING REQUEST

1. My hearing issue involves _____ (benefit program) and _____ County/Agency.
2. I want a hearing because: _____
3. Print name of person who needs a hearing: _____ Birthdate: _____
4. Mailing Address: _____ Phone number: _____
   ☐ I want to get hearing notices from the State Hearing Division by email. **Email Address:** _____
5. **Name/Signature:** _____ _____ **Date Signed:** _____
6. Interpreter: ☐ I want a **free** interpreter for the _____ language or dialect.
7. Disability Accommodation for hearing? ☐ No ☐ Yes (explain): _____
8. Your Hearing will be scheduled by phone. If you want your hearing conducted by a different method, tell us how:
   ☐ By Telephone ☐ By Video *(you see judge on your phone/computer)* ☐ In person at the county hearing site
   ☐ I have no phone or Internet access. I want to go and use the phone or video at hearing site for my hearing.
9. I need a faster scheduled hearing due to ☐ Denial of CalWORKs or CalFresh emergency benefits
   ☐ Medical Emergency ☐ Eviction/homelessness ☐ Other (explain): _____
10. If you timely appeal before the action listed in the notice takes place, your aid may stay the same. For CalWORKs (including Child Care) and CalFresh, if the county action was correct, you have to pay back any extra aid.
    ☐ Check to have your aid lowered or stopped pending the hearing for: ☐ CalWORKs ☐ Childcare ☐ CalFresh
11. You can have a friend, relative, legal counsel or other person help with your hearing. **If they have agreed**:
    Name: _____ Email: _____
    Address: _____ Phone: _____
12. **To Get Help:** These groups below may be able to give you legal advice or represent you at the hearing: