THE DISTRICT OF COLUMBIA DEPARTMENT OF HUMAN SERVICES
OFFICE OF PROGRAM REVIEW, MONITORING, AND INVESTIGATION
Request for Replacement of Stolen SNAP Benefits

For DHS Use Only:

_____

Date Received

If you lost your District of Columbia (DC) Supplemental Nutrition Assistance Program (SNAP) benefits from your Electronic Balance Transfer (EBT) card because of theft due to card skimming, cloning, or similar fraudulent methods, the DC Department of Human Services (DHS) may replace your benefits.

You will need to complete a separate form (DHS-16XX) to request replacement of cash benefits.

To request replacement of your stolen SNAP benefits:

1. Request a replacement card from FIS, the District's EBT card vendor, by either calling 888-304-9167 or visiting an EBT Card Distribution Center, located at either 645 H Street NE or 1649 Good Hope Road SE.
   - If you cannot go to an EBT Card Distribution Center immediately, call FIS at (888) 304-9167 to change your PIN
2. Fill out and submit a completed Request for Replacement of Stolen SNAP Benefits (DHS-1697 claim form) to OPRMI within thirty (30) days of the date you became aware of the loss of your SNAP benefits.
   - Submit a DHS-1697 claim form online
     - Visit dhs.dc.gov/page/fraud and click "Replacement of Stolen SNAP Benefits Form"
       - Do not submit a "Fraud Allegations Form" on dhs.dc.gov/page/fraud
   - Download a copy of the DHS-1697 claim form online at dhs.dc.gov/page/fraud or request a copy using the methods listed below and submit the DHS-1697 via mail or in person
     - Mail or drop off a completed DHS-1697 claim form to OPRMI at 64 New York Avenue NE
     - Apply in person with OPRMI at 64 New York Avenue NE between the hours 8:15 a.m. and 4:45 p.m.
3. You can request a DHS-1697 or obtain additional information from OPRMI using one of the three options below:
   - Call to speak directly with DHS personnel (202) 671-4460, then press "1" for a live representative between 8:15 a.m. and 4:45 p.m.
     - DHS has increased staffing to manage an influx of calls, but please expect extended wait times
   - Call the 24-hour OPRMI hotline at (202) 673-4464
     - Voicemail should include your name, DOB, and a phone number where you can be reached
   - Email OPRMI@dc.gov with the subject "Compromised Benefits," and provide details of your case, including your name, DOB, and a phone number where you can be reached.

You will be required to submit a completed DHS-1697 claim form and to get a replacement card before a claim is considered complete. After you submit your completed DHS-1697 claim form, OPRMI will need to verify that a loss occurred and that all required steps were completed. If your loss is verified, DHS will issue replacement benefits within twelve (12) business days after all required steps are completed.

DHS may deny your request for replacement benefits if you do not submit a completed DHS-1697 claim form reporting your loss within thirty (30) days of the date you became aware of the loss or if available evidence is insufficient to validate your request for replacement benefits. DHS can only replace SNAP up to the lesser of either the amount of benefits stolen or the amount equal to two (2) months of your monthly allotment immediately prior to the date when the benefits were stolen. SNAP benefits can only be replaced two times per program within a federal fiscal year (October 1 to September 30). **You will need to complete all the required fields on the next three (3) pages for this claim form to be complete.**

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Complete and sign this form under penalty of perjury to complete the process of reporting a loss of stolen SNAP benefits. Items marked with an asterisk (*) are required.

YOUR INFORMATION

_____	_____	_____
*First Name	Middle Name	*Last Name
_____	_____	_____
*Date of Birth	Case #	Last Four (4) Digits of EBT Card #
_____		_____
*Address		Apartment #
_____	_____	_____
*City	*State	*ZIP Code
_____	_____	
*Phone	Email Address	

CLAIM DETAILS

*On what date did you discover your benefits were stolen: _____

*Have you requested a replacement EBT card: ☐ Yes ☐ No

Date EBT card replacement was requested: _____

*Was your EBT card lost or stolen? ☐ Yes ☐ No

*Did you have your EBT card with you when your benefits were stolen? ☐ Yes ☐ No

*Do you believe that you were a victim of a form of electronic benefit theft, such as skimming or cloning? ☐ Yes ☐ No

You will need to list all transactions that you are reporting as stolen benefits on the next page and then review and sign the last page for this claim form to be complete. You will also need to request a replacement EBT card. Please see page 1 of this form if you have any questions about requirements.

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TRANSACTIONS

Please list all transactions that you are claiming were stolen due to card skimming, cloning, or similar fraudulent methods below. If you need to report additional transactions, please print and complete an additional copy of this page. Items marked with an asterisk (*) are required.

List each transaction on a separate line. Do not combine transactions that occurred at the same store/bank. If you need to confirm transaction details, you can call DHS's EBT card provider, FIS, at (888) 304-9167 or view your transaction history online at ebtedge.com or on your phone with the ebtEDGE mobile app.

*Date of Transaction	*Time of Transaction	*Store/Bank Name	Store/Bank Address or City/State (If known)	*Transaction Amount

You will need to review the penalty warnings and certifications on the next page and complete the signature fields below for this claim form to be complete. You will also need to request a replacement EBT card. Please see page 1 of this form if you have any questions about requirements.

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PENALTY ACKNOWLEDGEMENT

I understand that by signing this form, I am representing that the information I provided for this claim is true and accurate to the best of my knowledge, information, and belief.

I understand that misrepresentations of theft and/or false statements to DHS are a violation of DC and federal laws, and if I break these laws then I may be fined, go to prison, and/or be disqualified from program participation and not be able to receive benefits. I acknowledge that if I have knowingly given incorrect information about the facts stated above, I may be charged with an Intentional Program Violation (IPV) and/or may be subject to administrative, civil, or criminal penalties including, but not limited to, perjury for a false claim.

CERTIFICATION AND SIGNATURE

I authorize DHS to contact any person, partnership, corporation, association, or governmental agency that may have information relevant to this claim. I also authorize any person, partnership, corporation, association, or governmental agency which has information relevant to this claim to release that information to DHS.

I understand that if I do not submit a claim to DHS within thirty (30) days of the date I became aware of the loss of my benefits, DHS will not replace my benefits. I also understand this request for replacement of stolen benefits is not complete until I complete a DHS-1697 claim form and request a replacement EBT card.

I understand that the submission of this claim does not guarantee that my benefits will be replaced. I understand I have a right to a Fair Hearing if my request for replacement benefits is denied or delayed, and that replacement benefits will not be issued while a Fair Hearing decision is pending.

I swear or affirm that I have read or had read to me this entire application, including the penalty acknowledgement. I also swear or affirm, under penalty of perjury, that all the information I have given is true, correct, and complete to the best of my knowledge, information, and belief.

_____
Signature

☐ Self ☐ Authorized Representative
Relationship to Person Submitting Claim

_____
Printed Name

_____
Date