

# DHS-601, FOOD REPLACEMENT AFFIDAVIT - MANUAL

Michigan Department of Health and Human Services (MDHHS)

(Revised 4-25)

This form can be returned to your local office, submitted online at [michigan.gov/mibridges](http://michigan.gov/mibridges) or mailed to Michigan Department of Health and Human Services, PO Box 1735, Traverse City, MI 49685-9801.

## SECTION 1

Name	Social Security Number
Address	Case Number

## SECTION 2 - RECIPIENT REQUEST AND AFFIDAVIT

1. I wish to request a replacement of Food Assistance Program (FAP) benefits because food purchased with FAP benefits was destroyed. Please provide an explanation. (Attach other sheets, if necessary)

2. To receive replacement of your food benefits that were destroyed in the recent event, you must provide a dollar amount of the food that was destroyed.

I attest that the amount of food destroyed was \$

## SECTION 3 - CERTIFICATION AND ACKNOWLEDGEMENTS (Read Carefully Before Signing)

I swear or affirm under penalty of fraud and/or perjury that the information above is true.

I further understand that:

- If any person uses any FAP benefits that he or she is not entitled to, it is a violation of federal and state laws and is subject to a heavy penalty, and
- This completed form with my signature must be received by the local MDHHS office by the 10th day following the day I first report the loss to my specialist. If the 10th day falls on a weekend or holiday, it must be received by the next business day.

Client Signature	Date
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## SECTION 4 - SPECIALIST CERTIFICATION

(Complete this section to document approval of Replacement Issuance)

On the basis of the recipient's statement, I authorize the issuance of replacement benefits in the amount of \$

MDHHS Specialist Signature	Date	MDHHS Supervisor Signature	Date
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