



# STATE OF CONNECTICUT - DEPARTMENT OF SOCIAL SERVICES

## APPLICATION FOR THE DISASTER SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (D-SNAP)

W-799 (Rev 7/22)

<b>For Office Use Only</b>	IMPACT checked? <input type="checkbox"/> Yes
Card #: _____ Application Date: _____	Benefit Amount: \$ _____
Disaster Benefit Period: Begin: _____ End: _____	Household Size: _____
<b>All Household members entered in the ImpaCT database? <input type="checkbox"/> Yes</b>	

Complete this application truthfully and to the best of your knowledge. If your household refuses to give any requested information, D-SNAP will not be granted. You must provide proof of your identity when you are interviewed and may be required to verify your residency. You may have to prove any questionable expenses. You can give permission for someone else to apply for help or help you get and use your D-SNAP.

Head of Household	Authorized Representative name and address (if any)
Permanent Home Address and phone number	Temporary Address and phone number

List the people in your household, including yourself. **If you are temporarily staying with another household because of the disaster, do not list members of that household.** List each household member's Social Security number and date of birth. **List the source and amount of take-home pay (net pay after deductions) as well as any other income that is or will be received by your household during the disaster benefit period.** The Social Security number is not required by law but is helpful to identify your household members and to make sure they are eligible for D-SNAP. It may be used for computer matching program reviews or audits.

HOUSEHOLD MEMBERS					INCOME	
Household Member Name	Social Security Number	Birth Date	Are you Hispanic or Latino?	Racial Origin Code(s)*	Source/Type: Employment, Social Security Benefits, Pension, Unemployment, etc.	Total amount received/will receive during disaster benefit period
					<input type="checkbox"/> Yes <input type="checkbox"/> No Source _____	
					<input type="checkbox"/> Yes <input type="checkbox"/> No Source _____	
					<input type="checkbox"/> Yes <input type="checkbox"/> No Source _____	
					<input type="checkbox"/> Yes <input type="checkbox"/> No Source _____	
					<input type="checkbox"/> Yes <input type="checkbox"/> No Source _____	
					<input type="checkbox"/> Yes <input type="checkbox"/> No Source _____	

\*Racial Origin Code(s): **A** = Asian    **B** = Black or African Descent    **C** = White  
 (Enter a letter for all that apply.)    **N** = Native American or Alaska Native    **P** = Native Hawaiian or Other Pacific Islander

Are you or anyone in your household a current state of Connecticut employee?  Yes  No  
 If yes, who and what agency or department? \_\_\_\_\_

Are you or anyone in your household already receiving The Emergency Food Assistance Program (TEFAP) or Food Distribution Program on Indian Reservations (FDPIR)?  Yes  No  
 If yes, list who in your household \_\_\_\_\_

Are you or anyone in your household a current SNAP (formerly Food Stamps) recipient?  Yes  No  
 If yes, list who in your household \_\_\_\_\_

HOUSEHOLD SITUATION	Yes	No
Was your household living in the disaster area at the time of the disaster?		
Did your household buy food during the disaster benefit period?		
Did the disaster delay, reduce or stop your household's income?		
Does your household have money in the bank that you cannot access during the disaster period?		
Did your household have food destroyed in the disaster?		

List all cash your household will be able to get to during the disaster period. List the disaster-caused expenses that your household paid or expects to pay during this disaster. Do not include expenses that were paid or will be paid by someone outside your household.

HOUSEHOLD DISASTER RELATED EXPENSES	Yes	No	AMOUNT	HOUSEHOLD ASSETS	Yes	NO	AMOUNT
Dependent care due to disaster				Cash on Hand			
Funeral/medical expenses due to disaster				Checking Accounts			
Moving and storage costs due to disaster				Savings Accounts			
Temporary shelter expenses							
Cost to protect property during disaster							
Cost to repair or replace items for home or self-employment property							
Other disaster-related expenses Please list:							
Total disaster related expenses				Total household assets			

**PENALTY WARNING**

If your household gets D-SNAP, it must follow the rules listed below. We may choose your household for a Federal or State review sometime after you receive your D-SNAP benefits to make sure you were eligible for disaster aid.

- DO NOT** give false information or hide information to get or to continue to get D-SNAP.
- DO NOT** give or sell D-SNAP benefits or authorization documents to anyone not authorized to use them.
- DO NOT** alter any D-SNAP benefits or authorization document to get D-SNAP when you are not eligible.
- DO NOT** use D-SNAP benefits to buy unauthorized items such as alcohol or tobacco.
- DO NOT** use another household's D-SNAP benefits or authorization document for your household.

**CERTIFICATION AND SIGNATURE**

**I understand the questions on this application and the penalties for hiding or giving false information. My household is in need of immediate food assistance as a result of the disaster. I certify, under penalty of perjury, that the information I have given is correct and complete to the best of my knowledge. I also authorize the release of any information necessary to determine the correctness of my certification. I understand that if I disagree with any action taken on my case, I have the right to request a hearing.**

\_\_\_\_\_  
Applicant, Authorized Representative or Witness (if signed with an x)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Worker Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

<b>FOR ELIGIBILITY WORKERS USE ONLY</b>	
1. Total Income received or anticipated during the disaster period	\$
2. Total Accessible Cash Assets	\$
3. Add #1 and #2	\$
4. Total Disaster Expenses or DSED	\$
5. Subtract #4 from #3	\$
6. Maximum Gross Income Limit	\$
Eligible: #5 is less than or equal to #6	
Ineligible: #5 is greater than #6	
Worker Notes:	

This information is available in alternate formats. Phone (800) 842-1508 or TDD/TTY (800) 842-4524.

**USDA Nondiscrimination 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/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf>, from any USDA office, by calling (833) 620-1071, 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:**  
FNSCIVILRIGHTSCOMPLAINTS@usda.gov

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