

**Arizona Department of
Economic Security
Family Assistance
Administration
Electronic Benefit Theft
Replacement Request
Form**

**This form is used to
request replacement of
Nutrition Assistance (NA)
and/or Cash Assistance
(CA) benefits due to
electronic benefit theft.**

**See pages 14-19
for USDA/EOE/ADA
disclosures**

Examples of electronic benefit theft are card skimming, card cloning, and phishing scams. You may be able to receive a replacement when you report the electronic theft within 45 calendar days from the date the theft occurred.

To report and request a replacement of stolen NA and/or CA benefits, you, a household member, or Authorized Representative may complete and sign

this form. Submit your request by any of the following ways:

- **Call: 1 (833)786-8823, Monday through Friday, 7:00 a.m. – 5:00 p.m.**
- **Mail: Department of Economic Security PO Box 19009 Phoenix, AZ 85005-9009**
- **Fax: (602) 257-7031 or toll free to 1 (844) 680-9840**
- **In person: At any FAA Office**

(Please add your name and case number to any verification you are providing.)

Participant's Information

Participant's Name:

Date: _____

AZTECS Case Number:

Email Address:

Phone Number:

Cell Phone Number:

Best way:

and best time

to contact the household.

Details of Stolen Benefits

Last authorized purchase:

Program (NA or CA)	Date and Time	Amount	Name of Store or ATM	City and State

Specific purchase(s) being reported as stolen:

Program (NA or CA)	Date and Time	Amount	Name of Store or ATM	City and State

Additional Comments:

Was the Electronic Benefit Transaction (EBT) card in your possession on the date/time of the electronic benefit theft?

Yes

No

Note: A “no” response does not disqualify you from requesting a replacement of stolen electronic benefits.

Was the EBT card, number, or Personal Identification Number (PIN) given to anyone known or unknown? Yes No

Yes, I gave it to:

or I gave it to an unknown person through: (email, text, phone, in-person):

Was the EBT Card replaced since the unauthorized activity? Yes No

If yes, Date of replacement: _____

Attestation and Signature

This form is only valid with attestation and signature.

By signing, I agree with the statements below:

- I understand that reports of stolen electronic benefits must be reported within 45**

calendar days from the date of the theft.

- **I understand that only benefits stolen between 10/1/2022 through 12/20/2024 can be considered for replacement.**
- **I understand that replacement benefits due to electronic benefit theft cannot exceed the amount of two months of benefits or the amount of my actual reported loss,**

whichever is less.

- **I understand that benefits lost due to electronic theft cannot be replaced more than two times in a federal fiscal year (October 1st – September 30th).**
- **I understand that I have a right to an appeal to contest the amount, denial, or delay of the replacement issuance for my household. I understand that the**

replacement benefits would not be issued pending the appeal.

I affirm under penalty of perjury and/or fraud, that my Nutrition and/or Cash Assistance benefits were stolen. I understand that if I make false statements, I may be liable for an intentional program violation (IPV) or prosecution under both Federal and State laws.

**Participant's or Authorized
Representative's
Signature:**

Date: _____

Worker's (C or D) Number:

**DO NOT SEND FORM to the
Address below.**

**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 (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:

[\[COMPLAINTS@usda.gov\]\(mailto:COMPLAINTS@usda.gov\)**](mailto:FNSCIVILRIGHTS</u></p></div><div data-bbox=)**

This institution is an equal opportunity provider.

To request this document in alternative format or for further information about this policy, contact your local office; TTY/TDD Services: 7-1-1. •

Disponible en español en línea o en la oficina local.