

**Louisiana Department of Children and Family Services**  
**DISASTER SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM**  
**AFFIDAVIT OF DISASTER LOSS**

**Name (Head of Household):** \_\_\_\_\_  
**Social Security Number:** \_\_\_\_\_  
**Household Address:** \_\_\_\_\_  
**City/Town/State/Zip code:** \_\_\_\_\_  
**Parish:** \_\_\_\_\_

**SUPPLEMENTAL BENEFITS REQUEST**

I certify under penalty of perjury that my household experienced one or more adverse effects (loss of income, inaccessible liquid resources, or out of pocket, unreimbursed disaster-related expenses) as a result of the March 2016 Flood that occurred in my parish of residence during the period of March 8, 2016 through March 11, 2016. I understand that I will be subject to disqualification and prosecution and will be required to repay ineligible benefits if I knowingly give false, incorrect, or incomplete information in order to obtain or try to obtain food assistance.

**Adverse Effect (Please explain):** \_\_\_\_\_  
\_\_\_\_\_

**Client Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

Please provide collateral contact information in order for the State agency to verify your loss. Depending on the availability of power outage data or flood maps to verify your loss, the State agency may decide collateral contact information is not necessary.

**Name of Collateral Contact:** \_\_\_\_\_

**Street Address:** \_\_\_\_\_

**City, State, Zip Code:** \_\_\_\_\_

**Phone:** \_\_\_\_\_