



Maryland Department of Human Services
EBT Fraud Claim Attestation Form



Reporting Person Information (All fields with (*) must be answered)

Form section for Reporting Person Information including fields for First Name, Middle Name, Last Name, Suffix, Date of Birth, Email, Address, City, State, Zip Code, Phone Number, Case ID, Client ID, and Social Security Number.

EBT Card Information

Form section for EBT Card Information with a list of options for how benefits were stolen: Card Cloning, Phishing Scams, Scamming, Skimming, and I don't know.

Question: Did you have your EBT Card with you when your benefits were stolen? * Yes No

Answer the below question only if you have answered No to the above question

Question: Was your EBT Card lost or stolen? * Yes No

Answer the below questions only if you have answered Yes to the above question

Question: Date your EBT Card was lost or stolen (in mm/dd/yyyy if known)

Two questions: When did you last use your EBT Card before your benefits were stolen? (mm/dd/yyyy) and Where did you last use your EBT Card before your benefits were stolen?

EBT Fraud Suspect Information (Please provide if you are aware of any information about the suspect. If no, go to the next section.)

Question: Do you have any information about who stole your benefits? * Yes No

*If yes to the above question, please provide as much information you know.

Form section for Suspect Information including fields for Suspect's First Name, Middle Name, Last Name, Suffix, Address, City, State, and Zip Code.

Validation Data

Question: Did you file a police report? * Yes No

Please answer the below questions if your answer is Yes to the above question

Question: When did you file a police report? (If you are not sure of the exact date, please provide the closest date (mm/dd/yyyy))

Police Report Number (If you have the information)

What telephone number(s) do you use to call to check your EBT card balance? Enter the numbers here.
(Examples - Local Department of Social Services, EBT Helpline)

This will help us better protect your card in the future.

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Transaction Details
Please provide as many details as you can for us to help you.
Provide the amount of your benefits and date stolen (an estimated amount and date is okay)

Transaction Date	Amount Stolen * (Enter the amount you believe was stolen.)	Enter the date you believe your benefits were stolen. * (Provide an estimated date.)	Type of Benefits * (SNAP or CASH)	If you know, enter the name of the store where you believe your benefits were stolen.	If you know, enter the city where you believe your benefits were stolen.	If you know, enter the state where you believe your benefits were stolen.

Sworn Statement

The application will include the sworn statement below:
 "I declare under penalty of perjury under the laws of the United States of America and the State of Maryland that the information I have given on this form is true, correct, and complete to the best of my knowledge. I understand that if I knowingly give wrong information or leave out information that I know to be true and I get benefits that I am not eligible for, I will be responsible for repayment. I also understand that I may be disqualified from getting public assistance (including SNAP benefits) in the future. I further acknowledge that I can be fined and/or charged with a crime."

Signatures

I swear or affirm that I have read or had read to me this entire application. I also swear or affirm, under penalty or perjury, that all the information I have given is true, correct and complete to the best of my ability, knowledge and belief. I have received a copy of my rights and responsibilities. I authorize any person, partnership, corporation, association or governmental agency which knows the facts relevant to determining my eligibility to release that information to the Department. I also authorize the Department to contact any person, partnership, corporation, association or governmental agency that has provided information relevant to my eligibility for benefits. I certify, under penalty of perjury, by signing my name below, that the person for whom I am applying is a U.S. citizen or lawfully admitted immigrant.

Signature:

Relation to Claimant: Self Authorized Representative Other _____

Printed Name:

Date of Signature (mm/dd/yyyy):

For Agency Use Only:

Date Received: _____

NOTE: If you do not fully complete this form or fail to provide mandatory information as per the instructions, a final decision on your petition may be delayed.