

United States Department of Agriculture South Carolina Department of Social Services APPLICATION FOR DISASTER SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (DSNAP) (Pursuant to 7 CFR 280)			Application Date:	
			County:	
All applications will be considered without regard to age, color, race, sex, disability, religion, national origin or political belief.			Disaster Authorization Period:	
			Begin:	End:
PART A – HOUSEHOLD SITUATION (Please check all that apply below)				
1a. Are you currently a Supplemental Nutrition Assistance Program (SNAP) recipient? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, in what county: _____				
1b. Have you applied for or received DSNAP benefits already during this disaster? <input type="checkbox"/> Yes <input type="checkbox"/> No				
2a. Was your household living in the disaster area at the time of the disaster? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, answer the following questions:				
1. Did the disaster damage or destroy your home or self-employment property? <input type="checkbox"/> Yes <input type="checkbox"/> No				
2. Does your household have any additional expenses as a result of the disaster? <input type="checkbox"/> Yes <input type="checkbox"/> No				
3. Does your household plan to buy food before { _____ }? <input type="checkbox"/> Yes <input type="checkbox"/> No				
4. Did the disaster delay, reduce or stop your household's income? <input type="checkbox"/> Yes <input type="checkbox"/> No				
5. Does your household have any cash or money in checking or savings accounts which you cannot get because the bank/credit union/business is closed due to the disaster? <input type="checkbox"/> Yes <input type="checkbox"/> No				
PART B – HOUSEHOLD ADDRESS				
Permanent Home Address:		City:	State	Zip Code Telephone Verified <input type="checkbox"/>
Temporary Home Address:		City:	State	Zip Code Telephone
PART C – HOUSEHOLD MEMBERS			PART D - INCOME	
Name (Last, First, Middle	Birth Date MM/DD/YY	Social Security No.	Source	Monthly Amount
1. (Head of Household) Verified <input type="checkbox"/>				
2.				
3.				
4.				
5.				
6.				
If more than 6 household members, use DSS Form 3456 A.			TOTAL INCOME	
PART E – RESOURCES		Amount	PART G – ELIGIBILITY/BENEFIT COMPUTATION	
Cash on Hand			1. Income from Part D \$ _____	
Checking Accounts			2. Resources from Part E \$ _____	
Savings Accounts			3. Total (1 + 2) \$ _____	
Other Available Resources			4. Expenses from Part F \$ _____	
TOTAL RESOURCES			5. Adjusted Income (3 – 4) \$ _____ (If 4 greater than 3, enter 0)	
PART F – EXPENSES		Amount	Compare adjusted income to disaster income limits for the appropriate household size to determine eligibility and benefit amount.	
Cost to Repair or Replace Items For Home or Self-Employment Property			<input type="checkbox"/> Approved <input type="checkbox"/> Denied	
Dependent Care Expenses Due to Disaster			Date: _____	
Funeral/Medical Expenses Due to Disaster			Household Size: Allotment Amt:	
Moving and Storage Expenses Due to Disaster				
Temporary Shelter Expenses				
Expenses to Protect Property During Disaster				
Other Disaster Related Expenses				
TOTAL EXPENSES				
PART H – 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 certify that I have read the penalty warnings that were given to me. I understand that if I disagree with any action taken on my case, I have the right to request a fair hearing, orally or in writing.				
Signature of Applicant, Authorized Representative or Witness:			Worker Signature:	
Affix EBT Card Bar Code Label Here:				