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? ☐ **Yes** ☐ **No** If yes, in what county: _____

1b. Have you applied for or received DSNAP benefits already during this disaster? ☐ **Yes** ☐ **No**

2a. Was your household living in the disaster area at the time of the disaster? ☐ **Yes** ☐ **No** If yes, answer the following questions:

1. Did the disaster damage or destroy your home or self-employment property? ☐ **Yes** ☐ **No**

2. Does your household have any additional expenses as a result of the disaster? ☐ **Yes** ☐ **No**

3. Does your household plan to buy food before {_____}? ☐ **Yes** ☐ **No**

4. Did the disaster delay, reduce or stop your household's income? ☐ **Yes** ☐ **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? ☐ **Yes** ☐ **No**

PART B – HOUSEHOLD ADDRESS

Permanent Home Address:	City:	State	Zip Code	Telephone	Verified ☐
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 ☐				
2.				
3.				
4.				
5.				
6.				
If more than 6 household members, use DSS Form 3456 A.			**TOTAL INCOME**	

PART E – RESOURCES	**Amount**
Cash on Hand	
Checking Accounts	
Savings Accounts	
Other Available Resources	
TOTAL RESOURCES	

PART F – EXPENSES	**Amount**
Cost to Repair or Replace Items For Home or Self-Employment Property	
Dependent Care Expenses Due to Disaster	
Funeral/Medical Expenses Due to Disaster	
Moving and Storage Expenses Due to Disaster	
Temporary Shelter Expenses	
Expenses to Protect Property During Disaster	
Other Disaster Related Expenses	
TOTAL EXPENSES	

PART G – ELIGIBILITY/BENEFIT COMPUTATION

1. Income from Part D $ _____
2. Resources from Part E $ _____
3. Total (1 + 2) $ _____
4. Expenses from Part F $ _____
5. Adjusted Income (3 – 4) $ _____
   (If 4 greater than 3, enter 0)

Compare adjusted income to disaster income limits for the appropriate household size to determine eligibility and benefit amount.

☐ *Approved* ☐ *Denied*

Date: _____

Household Size:	**Allotment Amt:**

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: